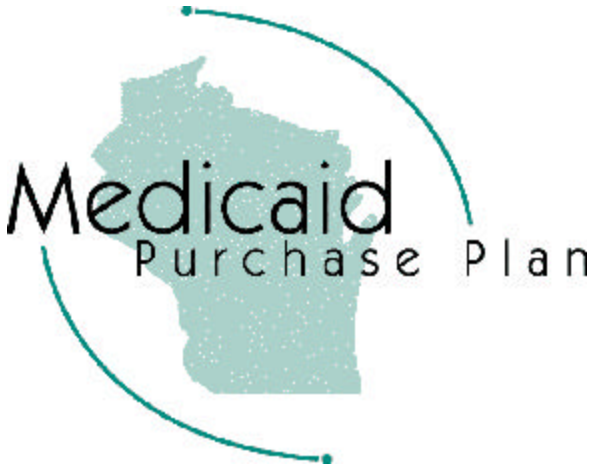
Medicaid Purchase Plan Evaluation
Annual Report



for

Center for Delivery Systems Development
and the Division of Health Care Financing
Department of Health and Family Services

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I. Executive Summary

The Department of Health and Family Services, Center for Delivery System Development (CDSD) contracted with Innovative Resource Group to conduct an evaluation of the Wisconsin Medicaid Purchase Plan (MAPP). MAPP was created by Wisconsin Act 9 and was implemented on March 15, 2000. MAPP provides Medicaid (MA) coverage to individuals with disabilities whose family income is below 250% of the federal poverty level (FPL).

This report summarizes the research and findings of the second year of the evaluation (through June 31, 2002), and compares these findings with those from year one where possible. The evaluation has three components: (1) impact, (2) fiscal and (3) process. The impact evaluation examines the effect of MAPP on enrollee's employment, earnings, savings, health care utilization and health status. The fiscal evaluation monitors the effects of MAPP on state, federal and local Medicaid and long-term care funding. The process evaluation determines if the program was implemented equitably across the state and whether the program is efficient and effective.

With a second full year of data available for analysis, this report provides a thorough analysis of the program's process, impact, and health care costs and utilization. The report takes advantage of three major sources of data that became available during the past year: MAPP enrollment data through the Client Assistance for Re-employment and Economic Support (CARES) system, Economic Support (ES) Worker Survey results and Recipient Survey results. Using these additional data sources in conjunction with the administrative program data already available, the evaluators were able to better assess the process and impact goals of the program during year two. In addition, the current fiscal analysis has built upon the fiscal analysis conducted last year and is considerably more robust in year two. The new fiscal analysis also includes a discussion of cost shifting from community based waiver programs to MAPP, and the use of third-party insurance by MAPP recipients. The report also provides baseline demographic data on the MAPP population.

Initially, enrollment in MAPP was modest, but by the end of the first year of the program over 1,300 individuals had been enrolled. After automation of the MAPP enrollment process in CARES in January 2002, enrollment increased dramatically. As of July 31, 2002, there have been almost 3,800 individuals enrolled in MAPP at some point during the first two years of the program. There are approximately 3,000 active MAPP participants during any given month. MAPP is a statewide program and nearly all of Wisconsin's 72 counties have enrolled at least one individual in the program. The majority of MAPP participants are between the ages of 35 and 64 with very few participants below the age of 25 or over the age of 65. The population is 51% male and 49% female. Over 63% had been enrolled in Medicaid in the month prior to MAPP enrollment and almost 87% had been enrolled in Medicaid at some point in time prior to their MAPP enrollment. The majority (81%) of participants are also eligible for Medicare.

Individuals whose income is over 150% of the FPL are required to pay a premium to participate in MAPP. Based on Medicaid eligibility data from July 2002, 14% of the eligibles were required to pay a premium. During the month of July, monthly premiums ranged from $25 to $875. Premium collections for state fiscal year (SFY) 2002 generated $493,010 in revenue for the

program. For an average month during SFY 2002, premium payments were equal to approximately 3.8% of total paid claims. During this period Medicaid benefit expenditures on behalf of MAPP participants totaled just over $13 million. Over one-half of all benefit costs were for prescription drugs.

Most of the issues identified in the previous annual report have not changed. While many of the administrative issues have been resolved with the automation of MAPP eligibility in CARES, BHCE may want to consider providing additional training or program information to the ES Workers. Even though CARES will automatically calculate each recipient's premium, ES Workers still need to possess a good understanding of the underlying program logic, such as how to identify appropriate Impairment Related Work Expenses (IRWEs) and Medical & Remedial Expenses (MREs), in order to accurately utilize the automated system. In addition, ES workers must be able to thoroughly explain the program to applicants, highlighting the benefits of the program, as well as any possible changes in current benefits that may arise from enrollment. BHCE may also want to provide additional clarification to county staff on the policies where there seems to be the most confusion (i.e. what counts as an IRWE). The MAPP Handbook was discontinued in March 2002; therefore, BHCE may want to provide this type of feedback in an operations memo, or by enhancing the MAPP Fact Sheet available on the internet.

In some counties, particularly Milwaukee County, potential MAPP applicants were reported to have had difficulties accessing the program because county ES workers did not understand the program eligibility requirements or were unavailable to process an application. The ES Worker Survey administered during year two supports the anecdotal information from year one, but also suggests that ES workers are becoming more familiar with the program and therefore, more able to assist potential enrollees. PTI Benefit Specialists also suggested that the existing work exemption policies are not well suited for the disabled population and may function as a barrier to enrollment. County staff have reported a need for additional outreach to identify and enroll more people who may be eligible for the program. ES Worker Survey feedback also supports this finding, suggesting that outreach is still much needed throughout the state.

In order to be eligible for MAPP an individual must be working or enrolled in the HEC program. In the first year of the evaluation, it was discovered that a significant number of MAPP participants reported $0 in earned income, but were not enrolled in the Health and Employment Counseling (HEC) program. As of July 2002, there were still a significant number of individuals (206) who report $0 income, but do not participate in HEC. The high number of individuals who appeared to be doing neither raised concerns about the coordination of MAPP and HEC, specifically raising questions about whether or not ES workers are verifying employment and making appropriate HEC referrals. It is also possible that using $0 earned income as a proxy for employment may not be valid, because several MAPP participants may be receiving in-kind compensation for their work. However, MAPP participant survey findings suggest that very few participants are receiving in-kind compensation. CDSD is currently working to develop a definition of employment that meets the needs of MAPP and also fits within current federal buy-in guidelines. A revised definition of work will help the ES workers with verifying employment and making appropriate HEC referrals.

CDSD has taken a number of steps to improve the effectiveness of HEC. For example, seven new .2 FTE Regional HEC Screeners were hired and a Statewide HEC Coordinator employed by Employment Resources, Inc. (ERI) was assigned. The initial HEC screeners were allowed to continue to participate in the HEC screening process in year two, acting as HEC liaisons. Unlike many of the initial HEC screeners, all of the new Regional Screeners have experience with disability benefits issues, benefits analysis and counseling, service and supports available to disabled consumers, and familiarity with disability employment barriers.

A considerable amount of effort was also directed toward improving outreach for HEC in 2002. ERI staff presented information on HEC and MAPP to new Pathways to Independence Benefits Counselors and Family Care Disability Benefits Specialists during a nine day benefits counseling training in February. Outreach was also conducted through the Bureau of Community Mental Health's monthly teleconference to the Wisconsin Public Psychiatry Network on January 24, 2002.

It remains difficult to determine if MAPP is allowing participants to earn more money without fear of losing health insurance and to save toward independence. Recipient Survey results suggest that MAPP has allayed much of the fear associated with losing MA benefits due to employment; however, it is still too early to tell if MAPP has truly allowed participants to earn and save more while enrolled in the program. Recipient Survey findings also suggest that saving among MAPP participants is less an issue of opportunity than an issue of ability. Most MAPP participants do not appear to have the available resources to begin saving at a significant level. The completion of data collection for the Recipient Surveys will provide a much stronger basis for generalizing to the entire MAPP population.

The availability of MAPP application data through CARES, specifically earned income information, will provide the best indicator to date of increases in earnings after enrollment. At this point, there is not a sufficient baseline against which to truly gauge increases in earnings. Future updates from CARES will provide the necessary data to conduct a comparison of earnings over time. The evaluators will also continue to work with the State to obtain more complete MAPP application data through CARES; specifically, IA, IRWE and MRE information.

The fiscal analysis conducted during the second year of the evaluation provides a thorough examination of the impact of MAPP on both Medicaid and long-term care (LTC) spending. However, administrative costs of the program remain difficult to determine. As a sub-component of the larger Medicaid system, MAPP administrative costs are not tracked separately from the administrative costs of the entire Medicaid program.

The year two fiscal analysis has shown that MAPP program spending per full-year equivalent[1] enrollee increased approximately 10% from the first to the second program year, due primarily to increases in prescription drug spending. A proportion of this increase is most likely related to general increases in prescription drug costs over time. However, the increase may also be the result of "pent-up" demand for needed services, specifically prescription drugs, among MAPP participants. Further analysis utilizing an MA comparison group to control for other contributing

[1] A full-year equivalent (FYE) is calculated as the total days enrolled in MAPP during the program year, divided by 365.

factors over time, including prescription drug inflation, showed that MAPP expenses are increasing at a rate above and beyond what can be explained by inflation alone.

Long-term care costs associated with state/federal waiver programs for MAPP enrollees did not change significantly following MAPP enrollment; however, it does appear that fewer program participants are accessing waiver services after enrollment in MAPP.

The third goal of the program – to offer an effective, efficient and equitable program - has been thoroughly addressed during the past year. Data collection and analysis has reinforced many of the preliminary findings from the first annual report: 1) MAPP administration has been "disjointed" at the county level, 2) county staff have exhibited varying levels of understanding regarding program policies and eligibility criteria, and 3) additional training to county ES workers and additional outreach among potential program recipients are needed. Feedback from the ES Worker Survey and MAPP Recipient Survey has substantiated these findings and provided tangible evidence that MAPP is slowly becoming more effective, efficient and equitable across the state. Similarly, Health and Employment Counseling (HEC) refinement and reorganization has substantially improved the consistency of MAPP administration across the state, as well as provided much needed outreach to the community.

One way to address confusion about program policies among MAPP applicants, participants and other stakeholders would be to distribute a final list of MAPP policies and guidelines to all county human service agencies. Several revisions were made to the MAPP Consumer Guide; therefore, it may be helpful to provide this type of final clarification. In addition, both county workers and program participants have requested tangible examples of program policies to clarify lingering eligibility related questions. For instance, examples of what to do if you can't work due to illness or if you lose eligibility as a result of failure to pay premiums would be very helpful to both the county worker and the participant. This type of clarification has been provided to the counties in the past; however, a final compilation of existing program procedures and possibly program rationale/philosophy may alleviate much of the confusion surrounding the program.

Independence Accounts continue to be an underutilized benefit. As of July 2002, CARES reports 54 active Independence Accounts (IA) representing 44 program participants. A zero balance was reported for 19 accounts (43% of all accounts). Considering that 43% of the accounts report a zero balance there does not appear to be any increase in savings toward independence. IRG and CDSD are working together to obtain more detailed IA information from county workers through CARES.

Perhaps more importantly at this point in the program, the findings support narrowing the definition of work within the current federal guidelines. The definition of employment is confusing to many county workers and recipients, causing wide variation among county workers as to what is considered valid employment. The definition of employment impacts enrollment and premium liability; therefore, the State could address several program issues by redefining "work" in the context of MAPP, bringing the program closer to it's original intent of providing an alternative MA program for working disabled who are capable of substantial work. CDSD is

currently working to develop a definition of work that meets the intent of the program and also fits within existing federal guidelines.

In addition, the evaluators propose stratifying future analyses by income, focusing specifically on any discernable differences between the MAPP participants who report $0 earned income and those who report some substantial level of earned income, perhaps income at the SGA or FICA levels. Stratifying future analyses based on income will allow the evaluation team and CDSD to better determine if MAPP is truly meeting its goals among the original target population, or if the impact of the program is masked due to heavy enrollment by individuals who do not meet the original intent of the program, and therefore, are not as likely to benefit from enrollment.

Lastly, the evaluation team will investigate the progress of Medicaid buy-in programs in other states[2]. The design team will investigate how effective other states' programs have been at enrolling members of their target populations, as well as areas of data collection that remain problematic in Wisconsin, such as administrative costs. The evaluation will also examine the eligibility and premium structures of each state as they compare to MAPP policies and procedures. Examining other states' buy-in programs, and how each program has addressed similar process issues to those faced by MAPP, may help provide new insight into addressing these process issues.

[2] States with buy-ins include: Alaska, Arkansas, California, Connecticut, Iowa, Maine, Mississippi, Minnesota, Nebraska, New Hampshire, New Mexico, New Jersey, Oregon, Pennsylvania, South Carolina, Utah, Vermont, and Washington. The following states are currently enacting buy-in legislation: Arizona, Colorado, Illinois, Indiana, Kansas, Missouri, Oklahoma, New York, Texas, and West Virginia. Some of these states are enacting legislation aimed at creating demonstration projects. Source: Folkemer, Donna, Jensen, Allen, Silverstein, Robert, and Straw, Tara. *Medicaid Buy-In Programs: Case Studies of Early Implementer States*. U.S. Department of Health and Human Services. May 2002.

II. Background

Section 4733 of the Balanced Budget Act of 1997 (Public Law 105-33) allows states to make available a new subprogram for individuals with disabilities whose family income is below 250% of the federal poverty level ($22,150 in 2002 for an individual). In Wisconsin, this subprogram is called the Medicaid Purchase Plan (MAPP). MAPP was created by 1999 Wisconsin Act 9 and was implemented on March 15, 2000.

Evaluation Contract

Under a contract with the Department of Health and Family Services, (DHFS) Center for Delivery System Development (CDSD), Innovative Resource Group (IRG) is conducting a three-year evaluation of MAPP. This annual report summarizes findings from year two of the evaluation, which began July 1, 2001 and ended June 30, 2002.

IRG is conducting the evaluation in partnership with The Management Group (TMG) and Electronic Data Systems (EDS). IRG offers diversified health care consulting services, specializing in decision support services, data analysis and reporting, program evaluation and other technical health care services. TMG is a management consulting and services organization with experience in health and long-term care. EDS is the Wisconsin Medicaid (MA) fiscal agent and specializes in data warehousing and data management.

Evaluation Components

The MAPP evaluation has three components: impact, fiscal and process. The impact evaluation examines the effects of MAPP on enrollee's employment, earnings, savings, health care utilization and health status. The fiscal evaluation monitors the effects of MAPP on state and federal Medicaid funding and examines the effects of MAPP on locally funded long-term care services. Finally, the process evaluation determines if the program is implemented equitably across the state and whether the program is efficient and effective. It also measures participant satisfaction through recipient and disenrollee surveys.

III. Program Overview

Program Goals

The purpose of MAPP is to provide people with disabilities an opportunity to overcome key barriers to employment. Specifically, the three stated goals of the program are to:

- Encourage people with disabilities to earn more income without risking loss of health and long-term care coverage.
- Allow people with disabilities to save and make purchases toward their independence, similar to opportunities currently available to the majority of the workforce.
- Offer an effective, efficient and equitable program to allow people with significant disabilities the opportunity to work without jeopardizing their health care coverage.

Eligibility Criteria

In order to be eligible for MAPP, an individual must be a Wisconsin resident and at least 18 years old. They must be determined as disabled by the Department of Health and Family Services (DHFS), Disability Determination Bureau (DDB). Recipients must also be working or enrolled in a Health and Employment Counseling Program (HEC) and have countable assets under $15,000. Countable assets include items such as cash savings, life insurance policies, and stocks and bonds, but do not include an individual's home or vehicle.

Program Features

In addition to providing health care coverage, the MAPP program includes a number of features designed to foster independence.

Enrollment in the Health and Employment Counseling (HEC) program provides individuals an opportunity to enroll in MAPP to secure health care coverage, while seeking employment. Enrollment in the HEC program temporarily fulfills the MAPP work requirement by requiring development of an employment plan consisting of benefit counseling, employment barriers assessment, and a plan to address all identified barriers to employment. Upon approval of the employment plan, the MAPP work requirement is waived and the applicant becomes eligible for the MAPP program for at least nine months, with the possibility of a three-month extension if necessary. If the enrollee remains unemployed after the three-month extension, he/she loses MAPP program eligibility. The HEC program is administered by Employment Resources, Inc. (ERI) under contract with the CDSD.

Once enrolled in MAPP, recipients can establish "Independence Accounts", which are intended to foster savings for items that increase personal and financial independence. By establishing an Independence Account, MAPP recipients can save earnings above the $15,000 countable asset limit for the program. Total annual deposits to Independence Accounts can not exceed 50% of gross earned income each year.

MAPP policies include a work exemption provision for individuals who are sick and need to take off of work for a period of time. Recipients who have participated in MAPP for at least six months are eligible for the exemption. The exemption itself can last up to six months and is limited to two exemptions every three years.

Health Care Coverage

The MAPP program offers health care coverage to eligible individuals. Family coverage is not available. However, if more than one family member has a disability, each person with a disability may be eligible for the program if he/she meets all of the eligibility requirements.

MAPP recipients are eligible for the same health care services available to any other group through Wisconsin's Medicaid program. These services are available at no cost to individuals whose total income is less than 150% of the federal poverty level (FPL). Individuals with a total income that meets or exceeds 150% of the FPL are required to pay a premium to participate in the program.

Premiums Requirements

Monthly premiums for MAPP are based on an individual's monthly income and family size. Spousal or other family member income is not counted in the premium calculation, but those individuals would be counted when determining family size. The amount of a MAPP recipient's premium is based on his/her adjusted earned and unearned income.

Unearned income includes Social Security benefits, disability benefits and pensions. Adjusted unearned income equals total unearned income less the following deductions:

- Standard living allowance ($648 per month for calendar year 2002)
- Impairment-related work expenses (IRWEs), such as work space modifications
- Medical and remedial expenses (MREs), such as attendant care

Earned income is income from paid or self-employment. Adjusted earned income equals gross earned income before taxes and any remaining income deductions from one's unearned income. In other words, if one's unearned income is less than the sum of the allowable deductions; the difference can be applied as a deduction to one's earned income.

Premium income is the sum of one's adjusted unearned income and 3% of one's earned income. In the following example, the applicant receives an $850 monthly SSDI payment and earns $1,200 per month. He spends $50 a month on cab fare to work and has $10 in medical payments per month.

Calculation of Monthly Premium

Monthly Unearned Income =	$ 850
Less Standard Living Allowance	*$ 648*
Less IRWEs	*$ 50*
Less MREs	*$ 10*
Adjusted Unearned Income	**$ 142**
Monthly Earned Income=	$1,200
Less Remaining Deductions	*$ 0*
Adjusted Earned Income	***$1,200***
	x .03
	$ 36
	+ 142
Premium Income	$ 178
Premium Amount[3]	$ 175

[3] Premium income between $175 and $200 results in a premium of $175. A premium Schedule is included as *Attachment A* in section VIII Appendix.

IV. Impact Evaluation

The purpose of the impact evaluation is to measure the impact of MAPP on participants' ability to earn more and save toward their independence while retaining their health care coverage. In addition, the impact evaluation will track participants' health status and health care utilization over time.

Information for the impact evaluation is drawn from a number of sources including:

- MAPP application data from the Client Assistance for Re-employment and Economic Support (CARES)
- Medicaid eligibility data
- Medicaid claims data
- Long-term care services data from the Human Services Reporting System (HSRS)
- HEC database data
- Recipient Survey data (Initial and Six Month Follow-Up)
- Disenrollment Survey data

As a result of the manual MAPP eligibility process utilized during the first 18 months of the program, it was necessary to develop a MAPP application database to capture data from the paper MAPP application. An Access application database was developed and data from this database was routinely downloaded to the MAPP universe*. Beginning in January 2002, all MAPP application information was entered through the CARES system directly by county Economic Support (ES) workers. As a result, the MAPP application database housed at IRG is no longer updated. All application data since automation in January 2002 is obtained directly through CARES, including all income and premium information.

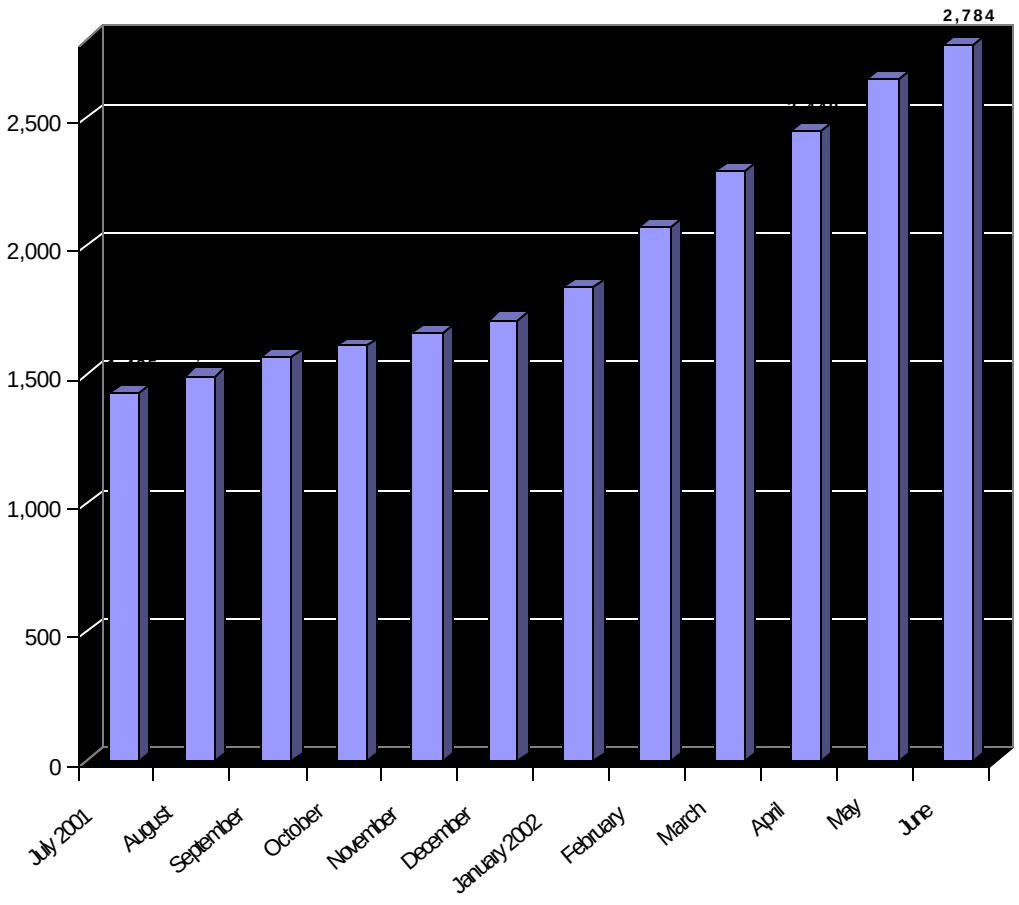
Enrollment Trends

Since the program's inception, MAPP enrollment has grown steadily, but in the last year, the program has experienced significant growth. Total enrollment in July 2002 was 2,933 individuals, more than double the enrollment in July 2001. It appears that most of this growth can be attributed to the automation of the MAPP eligibility process in CARES. As noted in the first annual report, the complexity of the manual enrollment process was seen by many county workers as a deterrent to enrollment. Consequently, it was expected that by making it easier for economic support workers to enroll individuals in MAPP through automation, MAPP enrollment would increase. In fact, since automation (January 2002), enrollment has grown by over 60%. In the six months prior to automation, new enrollment averaged 82 individuals per month. In the six months after automation, 222 individuals were enrolled each month, on average. [4] As of June 2002, a total of 3,365 individuals have ever been enrolled in the program. The following chart summarizes enrollment from July 2001 through June 2002.

[4] Automation was implemented in mid January. The average includes January through June 2002.

* A universe is a view of the data in a format that eases analysis.

Monthly MAPP Enrollment State Fiscal Year (SFY) 2001-02



Please see *Attachments B, C and D* in section VIII Appendix for month by month summaries of enrollment, disenrollment and pre-and post-MAPP Medicaid eligibility periods.

Dane County has enrolled 11.6%[5] of the total MAPP population, but only 5.7% of the statewide disabled Medicaid population was enrolled by Dane County. MAPP enrollments through Milwaukee County (7.2%) are up from year one (4.8%).[6] MAPP enrollees are also concentrated in Kenosha County (4.9%), Waukesha County (4.0%), Marathon County (3.3%), Winnebago County (3.3%), and LaCrosse County (3.1%).

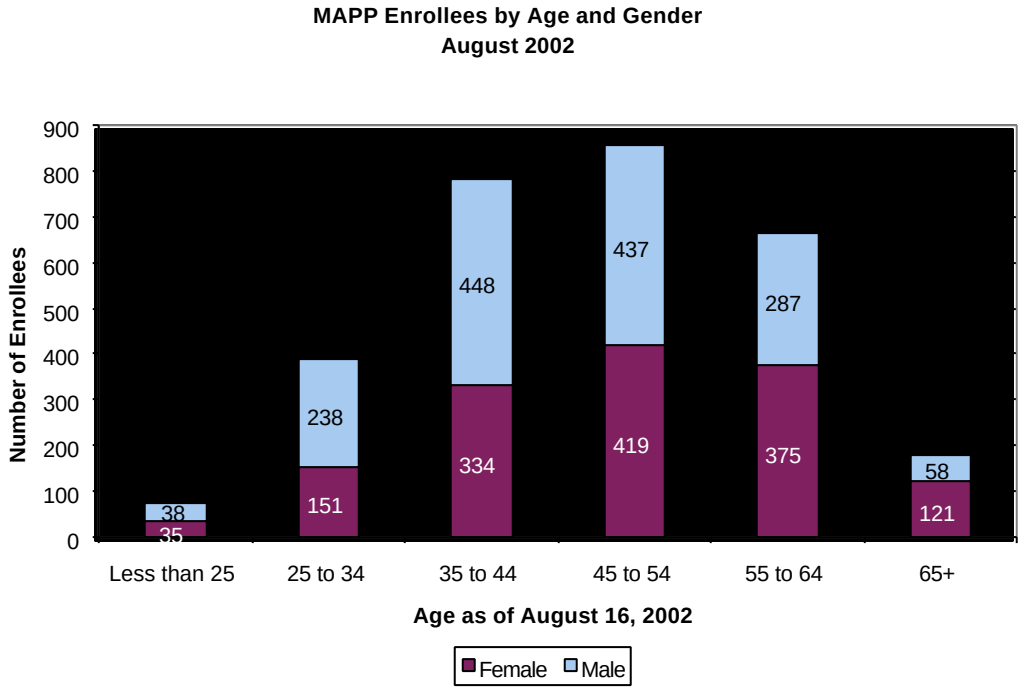
Attachment E in section VIII Appendix provides a full listing of MAPP and disability-related Medicaid certifications by county.

[5] Enrollment data by county was obtained from CARES in July 2002.

[6] Milwaukee County program enrollment is discussed further in the Process section of the report.

Demographic Data

As of August 16, 2002, there were 2,941 individuals enrolled in MAPP. The following chart provides a breakout of the population by age and gender.



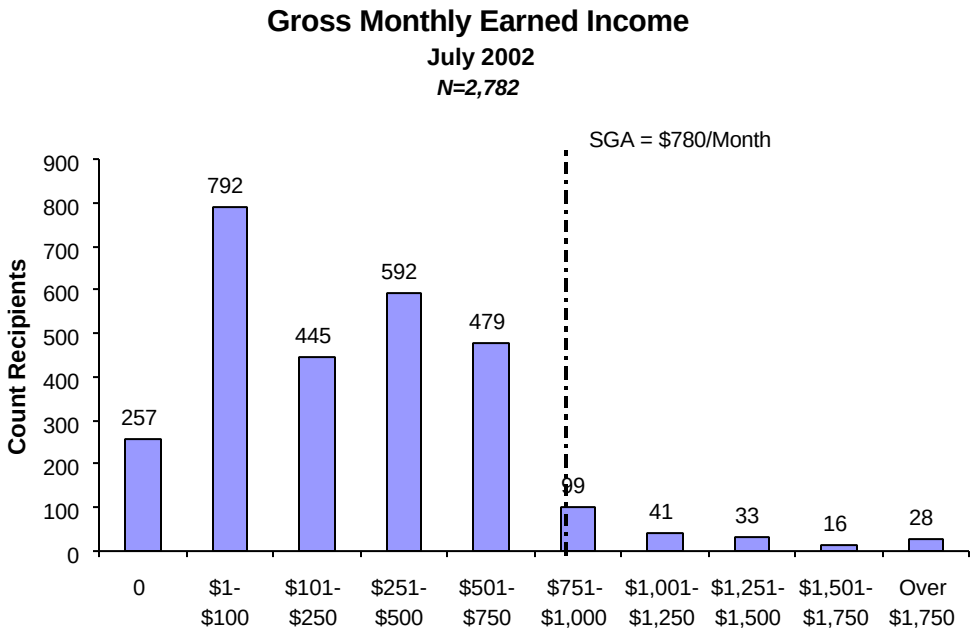
As the chart illustrates, almost 56% (1,638 or 2,941) of the participants are between the ages of 35 and 54, down 4% from year one. Approximately 51% (1,506 of 2,941) of the population is male, a slight (4%) decrease from year one. The proportion of men and women varies within each of the age categories, with the most disproportionate ratio occurring in the over 65 category, where 68% of the enrollees are female. Women represented 62% of the over 65 participants in year one.

In July 2002, MAPP recipients had earned income ranging from $0 to $4,870 per month with an average of $321.11 and a median of $204.90.[7] In comparison, MAPP participants in year one reported earned income ranging from $0 to $3,998 per month, with an average of $393.[8]

Average and median earned income in year two are well below the substantial gainful activity (SGA) level of $780 per month used by the federal government to determine social security disability eligibility. Disabled individuals earning above $780 per month risk losing their federal disability benefits[9], which may account for the large drop-off in wage earners above the SGA

[7] These figures include 2,782 enrollees with income information available through the CARES system. Earned income figures represent the latest monthly earned income reported by enrollees through CARES as of July 2002.
[8] Year one earned income data came directly from the MAPP paper applications submitted by each county to CDSD and aggregated by IRG.
[9] Individuals earning above $780 per month are only at risk of losing their Social Security Disability Income (SSDI) benefit.

level. However, the figures are close to the Federal Insurance Contributions Act (FICA) level of approximately $290 per month necessary to incur a tax liability. The following table shows the distribution of these recipients by the amount of their monthy earned income.



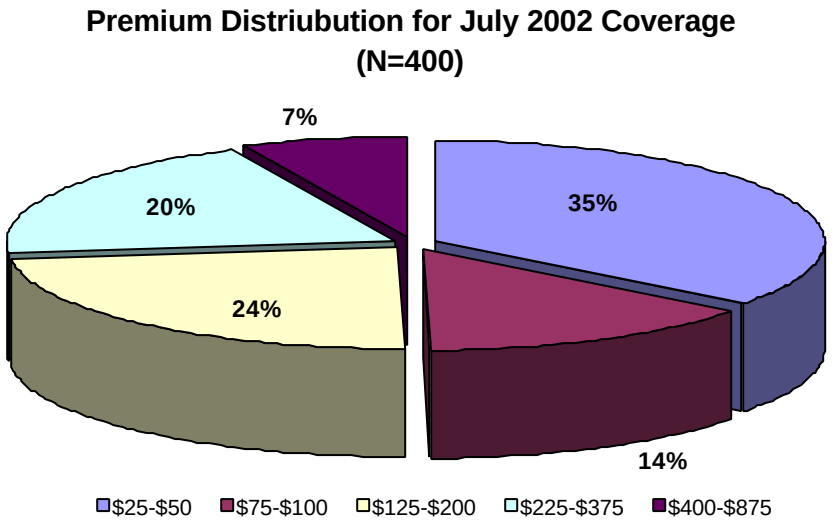
Source: CARES July 2002

Premium Status

MAPP participants whose gross individual income exceeds 150% of the federal poverty level (FPL) for their family size are subject to a premium. The majority of MAPP participants are not paying a premium to participate in MAPP. According to Medicaid eligibility data, the percentage of MAPP participants paying a premium averaged 14.7% per month for the first six months of 2002, peaking at 16% in April. *Attachment F* in section VIII Appendix provides a monthly summary of MAPP enrollment by premium status.

The amount of the MAPP premium varies dramatically among participants. For the July 2002 benefit month, premiums ranged from $25 (the minimum possible premium amount) to $875. Of the 400 individuals paying premiums for July coverage, over 35% were paying either a $25 or $50 premium[10]. Another 14% were paying a $75 or $100 premium and 24% were paying between $125 and $200. The remaining 27% pay premiums in excess of $200 per month. Of these, there are 28 individuals paying a monthly premium in excess of $400. The average premium collected was $152.02, up somewhat from $134.10 in July 2001. The sum of all premiums collected in July 2002 was $58,225. See the graph below for a summary of premium payment amounts.

[10] The premium schedule is set at increments of $25. For example, premiums are $25, $50, $75, etc.



For state fiscal year (SFY) 2001-02, MAPP premiums have generated $493,010 in revenues, helping to offset the costs of the program. For an average month during the 2002 SFY premium payments were equal to approximately 3.81% of total paid claims, an increase of only 0.1% from year one. *Attachment G* in section VIII Appendix provides a month by month summary of premium and claims payments for SFYs 2001 and 2002.

Medicaid and MAPP

The vast majority of MAPP participants were Medicaid eligible prior to their enrollment in MAPP. Of the 3,434 individuals who were eligible for MAPP between January 2000[11] and June 2002, 63% were enrolled in Medicaid in the month prior to their MAPP enrollment. Almost 3,000 (87%) were enrolled in Medicaid at some point in time prior to their MAPP enrollment. From the program's inception through June 2002, more than 680 individuals have disenrolled from MAPP at least once. The majority of the individuals who disenroll from the program subsequently re-enroll in non-MAPP Medicaid. A total of 638 individuals have had at least one post-MAPP Medicaid eligibility segment.[12] The majority of the post-MAPP Medicaid eligibility segments were SSI-related, as illustrated in the following table.

[11] While MAPP began in March of 2000, there were a number of individuals who had their initial eligibility backdated to January 2000. Under Medicaid policy, eligibility can be backdated three months from application if the individual would have met all eligibility criteria for those months.

[12] Please note that an individual may have more than one disenrollment and more than one post-MAPP eligibility segment. For example, as a result of changing income, a participant could have disenrolled from MAPP in February 2001; been on SSI-related Medicaid in March and April; re-enrolled in MAPP for May and June; disenrolled from MAPP and became eligible for non-MAPP Medicaid a second time.

MEDICAL STATUS GROUPS	# EX-MAPP ENROLLEES
SSI-Related	402
Waiver	93
SSI	76
Medicare Beneficiaries	68
BadgerCare	30
Nursing Home	18
AFDC	3
Healthy Start	3
Family Care (non-MA)	1
Total	**694**

Health and Employment Counseling (HEC) Enrollment

Changes to HEC[13] following the first Annual Report have had an impact on HEC enrollment. At the end of June 2001, there were 35 MAPP recipients representing 27 counties enrolled in HEC. As of July 2002, 126 MAPP recipients have been enrolled in HEC at some point, representing 36 counties. There are currently 68[14] active HEC participants.

Each HEC enrollee is required to identify at least one job goal on his/her employment plan. Most enrollees identified multiple job goals. The top three job goal categories in 2002 differ slightly from the top three categories in 2001. Computer and general office work (53%)[15] remains the number one job goal category and "assembly or manufacturing work" remains number two; however, "retail and sales" and "other" [16] tie for the number three category in 2002, replacing "janitorial or maintenance work." Janitorial or maintenance work fell to eighth (25%) overall, whereas "retail sales" improved from fifth in 2001, increasing from 17% to 30%. In addition, a new job goal category was added in 2002. Other professional jobs (29%) ranked fifth overall, accounting for occupations such as chemist, AA speaker, accountant, counselor and human resource specialist. *Attachment H* in section VIII Appendix summarizes the full listing of job categories.

Each HEC employment plan also identifies barriers that may prevent MAPP recipients from attaining their stated job goals. The 126 recipients listed in the 2002 HEC tracking database identified 424 potential barriers to employment collectively, many of which were duplicative. As in 2001, common barriers included: lack of skills, problems with transportation, stress, prior work history, medication side effects, other physical/mental symptoms associated with the recipient's disability, and the need for special accommodations. Barriers remained generally the same in 2002; however, several recipients identified new or more specific barriers, such as

[13] Changes to HEC are discussed in detail in the Process section of the report.
[14] The 68 active HEC enrollees represent applicants who have not exhausted their 9 months of eligibility (12 months if they received an extension), did not withdraw from the program and who are not currently employed based on the HEC tracking database records.
[15] Percentages are calculated as the proportion of **enrollees** who indicated a job goal within the identified job goal category, as opposed to a percentage of all job goals listed by the enrollees. The denominator in this case is 126.
[16] Other responses included animal caretaker, babysitter, beautician's assistant, farming, gardening and other miscellaneous occupations.

general anxiety over performance, ability to please their employer, and problems with stamina and endurance. In addition, recipients also indicated that "a lack of social networks," might be reducing their employment opportunities. This finding is particularly important given the importance social networks can play in identifying job opportunities.

Difficulties reconciling information from the HEC tracking database with the MAPP application database raised questions about the administration of the HEC program. At the time of the 2001 Annual Report, there were 84 MAPP enrollees reporting $0 earned income. Using $0 earned income as a proxy for lack of employment, it was expected that many of those 84 MAPP recipients were also enrolled in HEC; however, only 10 of the 84 (12%) were participating in HEC at that time. Repeating this analysis in year two shows that 253 (9%) MAPP recipients are currently reporting $0 earned income, and only 47 of these individuals are enrolled in HEC (19%).

These findings suggest that the new HEC outreach and enrollment procedures have slightly increased enrollment in HEC among members of the target population ($0 wage earners). However, the percentage of $0 wage earners enrolled in HEC remains very low. As discussed in the 2001 Annual Report, it may be that $0 earned income is not a reliable proxy for employment status (e.g. some of these individuals are "working," but do not have any countable earned income for MAPP) or it may be that there are individuals enrolled in MAPP who are neither working nor enrolled in HEC. In either case, further investigation into the reporting and collection of MAPP participant data is warranted (see the ***Process Evaluation*** section for more detailed information on HEC). The relatively high number of $0 wage earners is a MAPP program issue that continues to be a priority with CDSD and the evaluation team.

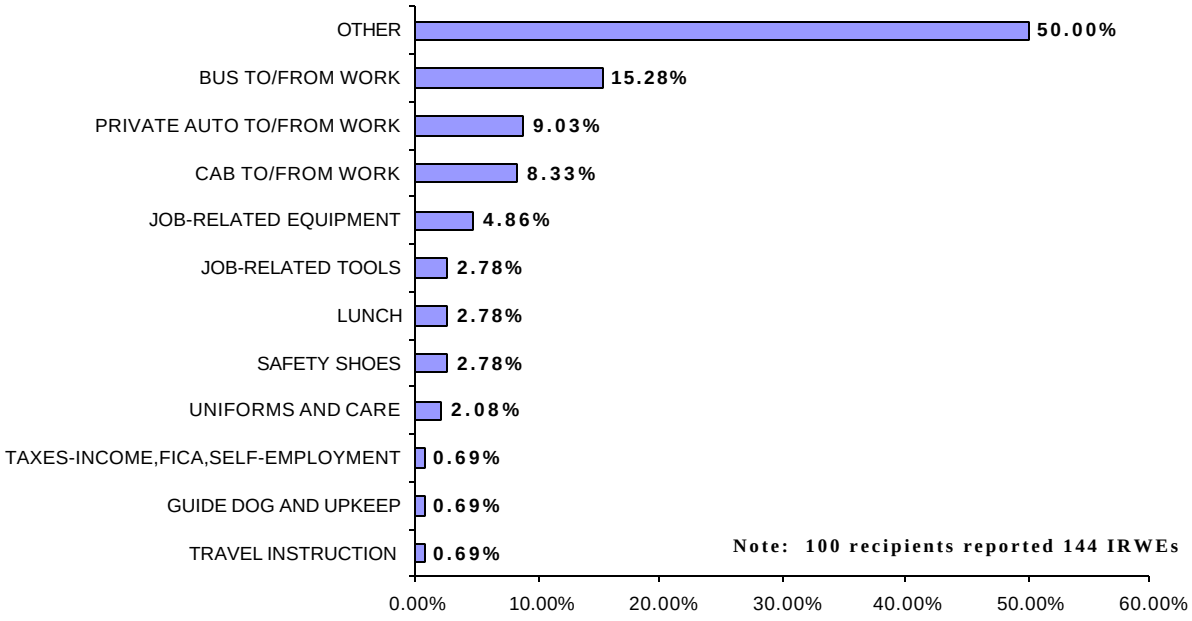
MRE and IRWEs

MAPP participants are allowed to deduct Impairment Related Work Expenses (IRWEs) from their income for the purposes of calculating financial eligibility and premium amounts for MAPP and are able to deduct Medical & Remedial Expenses (MRE) for the purpose of calculating premiums amounts. Information on MREs and IRWEs is collected by ES Workers as part of the MAPP application process. Detailed lists of IRWEs and MREs can be found in *Attachment I:* IRWEs and MRE Examples in Section VIII Appendix.

It appears that very few applicants are reporting MRE or IRWE expenses. July 2002 CARES data indicates that only 100 of 2,782 (3.6%) MAPP recipients report IRWE expenses. This is down somewhat from year one. The minimum expense identified was $2 and the maximum was $3,696.[17] While total reporting is down, the average expense is up by $50, an amount greater than could be expected from inflation alone. Transportation expenses accounted for over 32% of all expenses. The frequent use of the "other" category limits our ability to fully assess the functional needs of MAPP recipients. The following chart categorizes the 144 reported expenses, representing 100 recipients, by category as reported in CARES.

[17] No IRWE or MRE expense of $1 or less was considered when calculating the minimum or average expenses. Recipients reported one IRWE of $0 and one IRWE of $1. Four MREs of $0 were reported, as well as five MREs of $1.

Distribution of Impairment Related Work Expenses (IRWEs) by Type of Expense



Almost 10% of the applicants had identified MRE expenses on their application. The average MRE expense was $179.36. The minimum expense was $2[18] and the maximum expense was $8,844. Unfortunately, CARES reported all expenses as "out of pocket medical/remedial;" therefore, there is no way of identifying the types of expenses incurred by MAPP enrollees.

The identification of IRWEs is relatively new; therefore, it is not surprising that they have not been fully utilized. However, MREs are used throughout the Medical Assistance (MA) system and should be familiar to most county workers. It is hoped that ES workers will begin taking advantage of the 38 MRE codes available to describe MREs in order to provide more detailed information regarding these types of expenses in the future. IRG will work with CDSD and the counties to encourage county workers to use the available codes to solicit more detailed MRE information from their clients. Additional training on the use of IRWEs and MREs may be needed to increase awareness and identification of MREs among county workers.

Health Insurance Premium Payment (HIPP)

Under HIPP, Medicaid pays the "employee share" of the participant's or the participant's spouse's employer sponsored health insurance premium if it is cost-effective, thus reducing Medicaid expenditures. This benefit became available to MAPP participants in October 2001. The average monthly employee share for the employer sponsored insurance is $93.87. Currently, 27 MAPP recipients are participating in the HIPP program. An additional seven MAPP recipients have been approved for enrollment, but have yet to enroll. HIPP enrollment may be pending because individuals are not yet eligible for their employer's insurance program due to length of employment or an upcoming open-enrollment period. Fourteen recipients were

[18] See footnote 15.

eligible for HIPP, but never enrolled. In general, these individuals either lost MAPP program eligibility during the HIPP enrollment process or it was found not to be cost effective to buy into the employer's insurance policy. Employers ranged from Wal-Mart to Harley Davidson, covering retail, manufacturing, banking and customer service related employers. Because HIPP is a relatively new program, as it becomes more familiar to county workers, it is likely that HIPP enrollment among MAPP participants will increase.

The small number of HIPP participants suggests that either employer sponsored health insurance is not available to most MAPP participants, or HIPP is not cost-effective for most participants. HIPP enrollment will be monitored for possible expansion during year three of MAPP.

Recipient Surveys (Initial and Follow-Up)

Administration

Two versions of the MAPP recipient survey are being administered. The first, or "Initial Survey," was designed to be administered to individuals who are new to the MAPP program. The second, or "Follow-up Survey," is administered to participants at 6, 12, and 24 months after enrollment. Evaluation staff draw a monthly sample of participants for each survey. To minimize the burden to MAPP enrollees, and to reduce the cost of the evaluation study, the evaluation staff select a random sample of enrollees for questionnaire mailing and telephone interviewing, rather than administering a questionnaire to all MAPP enrollees. The sample survey uses probability sampling. This enables staff to give appropriate weight to each respondent so that the sample is representative of the whole population of MAPP enrollees over the course of the study period.

The MAPP Initial and Follow-Up surveys were field tested in mid-February, 2001 and surveys were mailed to the first cohort of MAPP participants in late February. Subsequent cohorts were drawn monthly, beginning in April 2001. Each cohort consists of two groups – new MAPP enrollees receiving the Initial Survey, and participants receiving the 6, 12 or 24-month Follow-up Survey.

The following protocol for contacting survey recipients has evolved during the course of the evaluation. A maximum of five attempts are made to contact each sample participant. At least two of the five attempts are made after 4:00 p.m. on weekdays or on Saturday. When a voice contact is made, the participant is invited to complete the survey questions at that time, or to schedule another time for the interviewer to call back and complete the survey. If the participant does not wish to complete the survey on the telephone, he/she is offered the option of completing the survey and mailing it back to TMG. A postage paid return envelope is then mailed to the participant to facilitate completion of the survey. If the participant (or a family member or guardian) declines to complete the survey, their name is removed from the sample database from which subsequent interview samples will be drawn. When contact is made with another individual who knows the participant well, such as a family member, social worker, or guardian, the interviewer offers that person the option of completing the survey on the participant's behalf, or helping the participant complete the survey if the participant is unable to complete the survey independently.

As of July 1, 2002, the following progress had been made on the administration of the Initial and Follow-up Surveys. Eight hundred sixteen (816) Initial Surveys and 884 Follow-up Surveys have been mailed. The table below summarizes the response rates for those participants for whom all contact attempts have been exhausted to date, for each survey.

Response	**Initial Survey Percentage** (N=816)	**6-Month Follow-Up Survey Percentage** (N=544)	**12-Month Follow-Up Survey Percentage** (N=210)	**24-Month Follow-Up Survey Percentage** (N=130)	**Combined Percentage**
Surveys Completed	28%	25%	25%	18%	26%
Refused*	30%	27%	36%	38%	30%
No Telephone Listing	29%	32%	13%	15%	28%
No Contact (5 attempts)	12%	14%	23%	27%	15%

*** "Refused" includes participants who told the interviewer they would mail in the survey, but failed to do so.**

Summary of Responses

The inability to make a voice contact with sample participants continues to be an obstacle to obtaining completed surveys. This includes participants for whom there is no valid telephone number ("No Listing"), as well as those who are not home or do not answer the telephone ("No Contact"). Overall, approximately 25% of the sample participants' records did not contain telephone numbers, so phone contact was not possible. In addition, many of the telephone numbers that were in the records were inaccurate (e.g. disconnected) or were for another individual, such as a guardian or a group home staff manager. The percentage of records without a telephone number has decreased considerably since the project has gained access to CARES data. (Since January 1, 2002, the rate of records without telephone numbers is 5%.) Although access to CARES has increased the availability of telephone contact numbers, many of the CARES-generated numbers are **also** incorrect or not active. As a result, the No Listing rate has not decreased during the past year.

The refusal rate is 17.8% across all surveys (16% for Initial Surveys, 19% for all Follow-up Surveys).[19] Of those who explicitly decline to participate, the most common reasons given included variations of "I don't have time," "I don't know what the MAPP program is," and "I didn't get the survey in the mail – send me another one and I'll fill it out myself."

Survey staff frequently field requests for additional information about MAPP. These requests are always referred to an appropriate source such as the Medicaid recipient statewide toll-free telephone number or the participant's local economic support office.

The follow-up survey response rates decline over time due to attrition within the program. Extending the period of data collection for the follow-up surveys beyond the third year of the evaluation would increase the number of follow-up responses, allowing for a more in-depth analysis of the of program participants with extended enrollment. In addition, extending the data

[19] The "Refused" rate in the response rate table above also includes those participants who told the interviewer they would mail in the completed survey, but failed to do so.

collection period for the follow-up surveys would also provide a larger longitudinal base for comparing participant experiences at different times throughout their enrollment.

Findings

Because survey administration is an ongoing process, results from surveys mailed in April, May and June were still being collected at the time of this analysis. Therefore, the following analysis is limited to responses from surveys mailed through March 2002. A total of 211 Initial Surveys and 147 Follow-Up Surveys had been completed at that time. Because the results are preliminary, only selected findings are reported at this time. A complete representative sample will not be available until year three.

The Initial and Follow-Up Surveys include questions on the following:

- basic demographics,
- recipient understanding of the program,
- financial status/work experience,
- physical and mental health/level of functioning,
- quality of health care, and
- satisfaction with the program.

Where possible, the analysis compares the results from the Initial and Follow-Up Surveys to identify changes over time. However, the results do not represent longitudinal findings for the same group of recipients over time, rather, the result are a general indication of recipient responses at enrollment and after 6 months of enrollment.

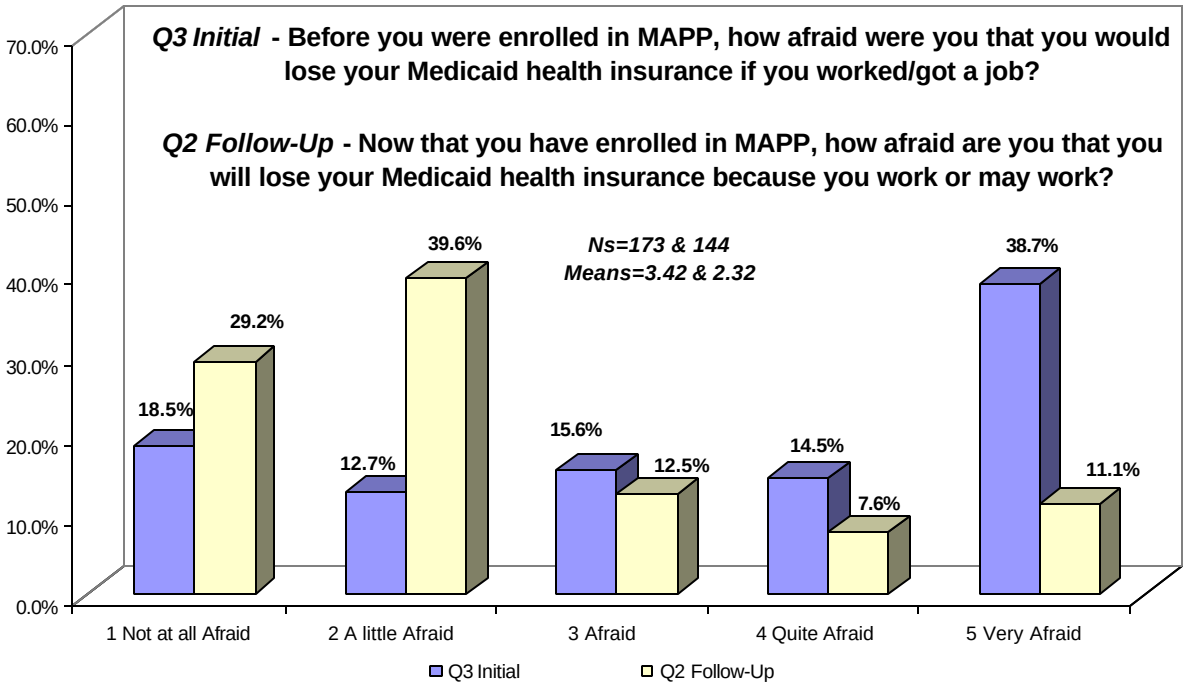
Demographics

Almost 90% of the initial respondents are Caucasian and non-Hispanic/Latino. Over 52% of the initial and follow-up respondents live in their own home or apartment, while 23% of the initial and 19% of the follow-up respondents live in someone else's home or apartment. Very few respondents live in a residential setting, such as a group home or residential care complex. MAPP participants tend to be single. Just over 52% of the initial respondents and 50% of the follow-up respondents have never been married. Twenty-two percent of the initial and 24% of the follow-up respondents have been divorced, while only 15% and 16%, respectively, report being married. A large percentage (24%) of initial respondents have not attended high school; however, 48% of initial respondents have graduated from high school and/or have some college education.

Fear of Losing Health Care Coverage

MAPP was developed, in part, to address the fact that individuals with disabilities are not able to work as much as they would like because increased earned income would cause them to lose their MA health care coverage. Therefore, Initial Survey respondents were asked, prior to their enrollment in MAPP, how afraid were they that they would lose their MA coverage if they began working. Prior to MAPP enrollment, over 81% of respondents were at least "a little afraid" of losing their MA coverage if they began working. After six-months of enrollment, approximately 71% of the follow-up respondents reported at least some fear of losing their benefits due to work. However, only 11% of the six-month follow-up respondents reported being "very afraid" of losing their health care benefits because of work,

as opposed to 39% of the initial respondents. The chart below illustrates that the fear of losing health care benefits due to work lessens dramatically with extended experience in MAPP.



Financial Status/Work Experience

When asked to identify their sources of income, 85% of respondents to the Initial and Follow-Up Surveys indicated that they had income from a job. Income from a job and income from disability payments accounted for the majority of income. Among initial respondents, income from a job accounted for 43% of all sources of income disability payments accounted for an additional 42%, suggesting that the working disabled still depend heavily on their disability benefits for support[20]. This pattern holds true for follow-up respondents as well.

When asked how much they reported being able to save in the previous 6 months, the majority of initial and follow-up respondents had saved nothing. Only 34% of initial and follow-up respondents were able to save during the previous six months. This finding suggests that MAPP is not currently meeting its goal of helping program participants save while enrolled in the program. Of those initial and follow-up respondents who did save during the previous six months, only 23% and 24% respectively, reported saving over $100.

Given responses to questions about how the new opportunity to save has changed their thinking about the future, it is apparent that saving among MAPP participants is less an issue of opportunity than an issue of ability. Most MAPP participants do not appear to have the available resources to begin saving at a significant level.

[20] The remaining 15% of income comes from investments, support from family/friends, other government assistance or "other" sources.

Respondents were asked how many hours they work in a typical week. Only 8% of initial and follow-up respondents worked between 30 and 40 hours per week, with less than 2% working more than 40 hours. Interestingly, 17% of initial respondents reported working between 0 and 5 hours per week, whereas 28% of follow-up respondents reported the same amount of work. Given that MAPP is intended to encourage employment, it was not expected that follow-up respondents would report working less than initial respondents.

Almost all of those who report working are receiving money as compensation. This finding was unexpected. It had been thought that the high numbers of individuals reporting less than $100 in monthly income were receiving in-kind compensation in addition to or in place of monetary compensation. However, only 1% of initial and 2% of follow-up respondents report receiving in-kind compensation as their sole source of income, and fewer than 4% of initial and 3% of follow-up respondents report receiving both money and in-kind compensation. These findings suggest that even participants receiving less than $100 per month in income are typically not receiving in-kind compensation.

Initial and follow-up respondents reported that their employers were for profit businesses (58% and 66% respectively), non-profit businesses (17% and 19% respectively) and sheltered employment (10% and 10%, respectively).

To better understand the employment experiences of very low earners, additional data collection and analyses needs to be conducted. It may be helpful to modify the recipient surveys to include follow-up questions for respondents who report very low wages. It may also be helpful to follow-up these findings with a select group of willing program participants to better determine what type of employment they are engaged in and how they are compensated. These follow-ups could be conducted as focus groups or phone interviews, for example.

Also of note, a very small percentage of respondents to the Initial Survey (13%) and the Follow-Up Survey (3%) reported employment with local or state government agencies. No one reported working for a federal agency. Over 86% of all employed respondents work outside of the home. Also of interest, almost 90% of the follow-up respondents have been with their current employer for over 6 months, whereas only 72% of the initial respondents have been with their current employer for over 6 months. This finding suggests that MAPP does improve employment stability among program participants.

The most common job categories for initial respondents were service/maintenance (57%) and secretarial/clerical (16%). However, among follow-up respondents, both of these job categories were less common, 52% and 10% respectively. Follow-up respondents reported more skilled craft positions (15%) than did initial respondents (8%), as well as more professional positions, 7% versus 4%. Until all results are tabulated, it is difficult to interpret this finding. It is possible that MAPP has helped a small percentage of program participants move into more skilled positions, but it is also possible at this point in the data collection process that the current follow-up respondents simply represent a slightly “higher skilled” subset of all MAPP enrollees. Until a sufficient number of returns have been collected to ensure a representative sample, it is impossible to interpret this finding with any certainty.

In a related question, respondents to each survey were asked to identify the "type of business, industry, (or) organization where you currently work?" Over 27% of initial respondents identified "other services or repairs," followed by retail sales (15%) and hospitality (12%). In contrast, 41% of follow-up respondents identified "other service or repairs," retail sales (10%) and human services (9%). By comparison, over 53% of the job goals identified by HEC enrollees were for computer or general office work. Other than this difference, the remaining job goals identified by HEC enrollees closely paralleled the actual types of businesses currently employing MAPP participants. These businesses include assembly and manufacturing, retail and sales, health and human services and other "professional" jobs. This suggests that most MAPP participants are setting realistic employment goals.

Beginning with job satisfaction, several employment related questions were asked of the initial and follow-up respondents, specifically focusing on barriers to employment and experiences with HEC. Over 82% of initial and follow-up respondents report being satisfied or very satisfied with their present job.

Over 34% of initial and 33% of follow-up respondents reported that they wanted to work more hours. However, poor health was cited by the majority of those respondents as preventing them from working additional hours. Almost 27% of initial respondents also indicated that they had "no opportunity to do so (work)," whereas only 3% of the follow-up respondents reported having "no opportunity" to work. This finding suggests that over time MAPP is providing an opportunity to work for most recipients who previously could not.

Initial respondents were provided a list of work barriers and asked to identify all barriers that they had experienced. Similar to the findings from above, poor mental or emotional health was the most common barrier to work cited by initial respondents (18% of all barriers listed), followed by physical limitations (16%), and fear of losing health insurance (14%). As a follow-up to this question, initial respondents were also asked to rate the importance of the "fear of losing your Medicaid health insurance" as a barrier to work. Over 46% of initial respondents indicated that the fear of losing their Medicaid health insurance was "the single most important barrier" to work. An additional 22% felt that the fear of losing their health insurance coverage was "one of the most important barriers" to work.

Respondents to both surveys were asked if private health insurance through their employers had become more accessible after enrolling in MAPP. Very few respondents (8% initial and 6% follow-up) indicated that private insurance had become more accessible since their enrollment in the program. This is consistent with findings related to HIPP, where very few MAPP participants are also participating in the HIPP program.

A fair number of respondents (33% initial and 26% follow-up) are looking for more challenging jobs, or want to change jobs (15% initial and 15% follow-up). Of those who wanted to change jobs, 21% of the initial and 28% of the follow-up respondents were in search of higher wages. Other common reasons for seeking a new job among both

respondent groups included "no chance for advancement at current job," "current job is too easy," "too few hours," and "current job is poor fit for my skills."[21, 22]

Physical and Emotional Health/Level of Functioning

The following results are preliminary and should be interpreted carefully. Data collection for the Initial and Follow-Up Surveys will not be completed until the spring of 2003. However, the results discussed below do provide an initial picture of some key characteristics of the MAPP population.

In general, most survey respondents report being in good or fair health. Forty-three percent of the follow-up respondents rated their health as fair and 32% rated their health as good. In comparison, 37% of the initial respondents rated their health as fair and 36% rated their health as good. Initial respondents spent an average of $2,912 on independence related items in the previous year. In contrast, follow-up respondents enrolled in MAPP for at least 6 months of the previous year spent an average of $722 on independence related items. While these are preliminary results, this suggests that enrollment in MAPP has a dramatic impact on independence-related items spending.

Several survey questions were included to assess recipient level of functioning and level of assistance received from friends and family members. Over 41% of initial and 37% of follow-up respondents stated that they need no physical help and support from others for day-to-day activities. The majority of initial (56%) and follow-up (56%) respondent are limited at least "a little" by their health during **moderate** activities. Only 17% of initial and 13% of follow-up respondents indicated that they need "quite a bit" or "a great deal" of help from others for day-to-day activities.

A larger percentage of respondents require emotional help than require physical help. Thirty percent of initial and 34% of follow-up respondents require "a little" emotional help and support from others. Twenty-six percent of the initial respondents need "quite a bit" or "a great deal" of emotional support from others. When asked how much physical and emotional support for day-to-day activities they receive from **family or friends**, 45% of initial and 43% of follow-up respondents stated "quite a bit." Over 42% of initial and 38% of follow-up respondents also indicated that they receive "quite a bit" of physical and emotional support from medical workers, including social workers, case managers, in-home workers, and other caregivers.

Forty-six percent of initial respondents plus 52% of follow-up respondents report that their physical or emotional health has interfered with their social activities "a little of the time" or "some of the time" during the past four weeks. Over 31% of each group stated that their health does not interfere with their social activities. Approximately 23% of the initial and 21% of the follow-up respondents reported that their health stops them from "getting around"

[21] These findings should be interpreted with caution given the small number of respondents to this question. Only 44 initial respondents and 29 follow-up respondents provided reasons for wanting to change jobs.

[22] Additional information regarding HEC enrollment and employment plans was collected; however, the number of respondents to these questions is generally too small to allow for interpretation. Therefore, these responses have been excluded from the summary of findings.

either "quite a lot" or "very much." Health also limited the respondents' leisure activities. Thirty-eight percent of the initial respondents reported being limited by health during leisure activities, compared to 30% of follow-up respondents.

Given that MAPP is a program designed for workers with disabilities, the responses summarized above suggest that MAPP is targeting the appropriate population; however, the low rate of employment and relatively low earned income reported earlier suggests otherwise. Due to the relatively low number of respondents, these findings should be interpreted carefully until all data collection is complete.

Quality of Health Care

In addition to the information gathered above, MAPP participants were also asked to rate their health care providers. Beginning with the "health care provider who knows (them) best[23]," respondents were asked to rate that provider on a scale from "0-worst health care provider possible" to "10 – best health care provider possible." MAPP participants seem very satisfied with their primary providers. Primary health care providers averaged a score of 8.45 among initial respondents and 8.33 among follow-up respondents. Less than 3% of initial or follow-up respondents rated their primary health care provider a 3 or lower. Results were very similar for care provided by others besides the recipients' personal doctors or nurses. The average rating of care given by providers other than a personal doctor or nurse was 7.8 among initial respondents and 8.07 among follow-up respondents. **ALL** health care was rated similarly among both groups of respondents. Initial and follow-up respondents rated their overall health care an average of 8.13 and 8.05, respectively.

Overall Satisfaction

Survey participants were very satisfied with the MAPP program. Ninety-six percent of initial and 99% of follow-up respondents would recommend MAPP to other people with disabilities. Over 86% of initial respondents and 84% of follow-up respondents reported being satisfied or very satisfied with MAPP. Fewer than 2% of initial and 5% of follow-up respondents were dissatisfied or very dissatisfied with the program.

Disenrollment Survey

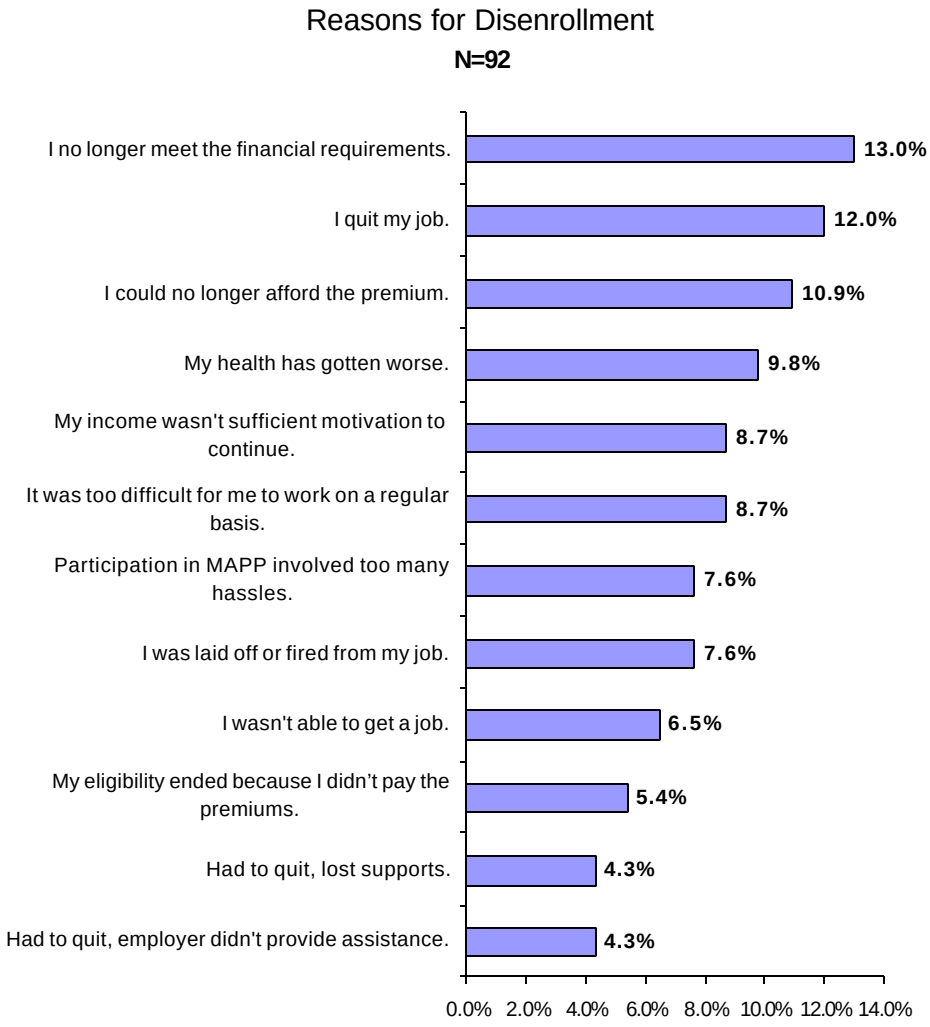
In conjunction with the initial and follow-up surveys, the evaluators have also administered a survey to better understand program disenrollments. The survey examines the recipients' decision to disenroll, as well as the effectiveness of MAPP in allowing the recipients to maintain their health coverage while working and save while enrolled. The survey also addresses general satisfaction with MAPP during enrollment.

As with the previous two surveys, these results are preliminary and data collection will not be completed until June 2003. Disenrollment surveys are distributed quarterly. As of May 2002, 395 disenrollment surveys had been mailed to former program recipients. Current results include 73 surveys completed through June 2002, representing a response rate of 18.5%. This rate is respectable considering that respondents are no longer participating in the program and have little incentive to complete the survey. The response rate is also affected by the fact that a number of disenrollments result from deaths among program participants.

[23] The health care provider could be a general doctor, a special doctor, a nurse practitioner or a physician assistant.

The majority (78%) of respondents disenrolled from MAPP because they were no longer eligible for the program. Disenrollees who did not lose eligibility were asked if they could have continued in the program but chose not to (10%), or if they could have continued but were encouraged by MAPP staff to disenroll (1.7%). Ten percent of the respondents agreed with staff that they should disenroll, although they could have continued their eligibility. Without direct follow-up, it is difficult to speculate on the circumstances that would result in such a disenrollment.

Respondents were provided 13 potential reasons for disenrollment and asked to identify **all** that applied. The most common reason for disenrollment was that the respondents no longer met the financial requirements of the program. Detailed results can be found in the following chart.



In addition to the disenrollment options listed on the survey, respondents also had an opportunity to identify other reasons for disenrollment. Forty disenrollees provided additional reasons for their disenrollment, ranging from "I married in September and was eligible for a program without a premium," to "I have only a part-time job and have a high rent to pay, and a car

payment. It was hard to come up with the money to pay MAPP." Other reasons for disenrollment included moving out of state, temporary/seasonal employment, and case worker turnover (missed renewal period). Several respondents indicated that their premiums were prohibitive. One respondent stated, "I found out that my IRWEs were not allowed as my vocational support is paid by my benefits and is not paid directly out of my pocket. So I ended up with a $350 per month premium, which is way too expensive for me to be able to continue participation in the program."

The majority of MAPP participants, 79.5%, felt that MAPP met their expectations for retaining their health insurance. Reasons for MAPP not meeting expectations ranged from a participant having to pay $150 per month to stay enrolled to another recipient who felt that he received no follow-up help after enrollment. One participant had a bad working relationship with MAPP staff and another did not know that they had been enrolled in MAPP.

Over half of the MAPP participants, 56.2%, were able to meet their expectations of saving while they worked. MAPP participants that were not able to save while on MAPP cited low wages as the primary reason for not saving. Other participants stated that premiums were too high, which inhibited their efforts to save.

The disenrollment survey also measured satisfaction with the program. Overall, former participants were satisfied (39%) or very satisfied (38%) with MAPP. However, 11% were very dissatisfied with the program. These findings suggest that MAPP is generally meeting the needs of most recipients, yet some program issues remain unresolved. When asked if they would re-enroll in MAPP given the chance, 71% indicated that they would, while 11% would not[24]. These findings support the previous findings of overall satisfaction with the program.

Lastly, respondents were asked to comment on changes to MAPP that could improve the program. Respondents typically reported that premiums were too high, income and asset caps were too restrictive, there was difficulty with coordinating benefits, and the basic eligibility requirements of the program were not well understood. One respondent noted that there was a significant lack of coordination between his health care provider, his county worker and the state, which resulted in loss of benefits and general frustration among everyone involved. While MAPP provides access to health care services, it does not necessarily provide supportive services such as coordination of care. Based on this feedback and similar feedback from other sources, it appears that there may be a need for more formal coordination of services.

[24] The remaining 18% of respondents chose not to answer this question.

V. Fiscal Evaluation

Background

The purpose of the fiscal evaluation is to monitor the effects of MAPP on state and federal Medicaid funding and to measure its impact on locally funded long-term care services. While the MAPP program has its own set of eligibility requirements and program policies, in terms of its administration it is functionally a sub-component of the larger Medicaid program. As such, its administrative costs (operational staff, local enrollment staff, eligibility and claims processing) are not discernable from other Medicaid administrative costs. In other words, MAPP administrative costs are not accounted for separately by the state. Consequently, our analysis of the effect of MAPP on State and Medicaid funding is limited to direct service costs associated with the program[25].

The fiscal evaluation also examines information from counties regarding the impact of MAPP on their local long-term care budgets. It had been expected that MAPP would provide some financial relief to counties by creating opportunities to shift county funded long-term care costs to the Medicaid program by making more working disabled individuals eligible for Medicaid. Measuring this goal poses a challenge because counties generally do not keep comprehensive records of long-term care cost at an individual level so that MAPP participants who had previously been receiving county funded services can be readily identified. Counties also subcontract with other community providers for the provision of long-term care services, which makes tracking individual costs very difficult.

The fact that the majority of MAPP enrollees were participating in Medicaid just prior to their MAPP enrollment also poses a challenge for measuring the impact of MAPP on the overall Medicaid budget. Evaluation staff has worked with CDSD staff to develop a model for identifying the fiscal impact of MAPP on the Medicaid budget. This model considers a number of factors, including: (a) changes in Medicaid costs that can be attributed to participation in MAPP (i.e. impact of work on health status); (b) the impact of MAPP premiums on program costs, and (c) other factors that may influence expenditures. A comparison group was used to control for as many of these factors as possible.

The extent to which MAPP participants are engaging in substantial work has a direct result on the findings presented in this report, including the fiscal analysis presented below. Over 90% of MAPP participants have not reported earnings at the substantial gainful activity (SGA) level of $780 per month and most (58%) report monthly earnings below the FICA level of $290 per month. Therefore, it is possible that the results of the fiscal analysis would differ if conducted solely with program participants whose monthly earned income demonstrates substantial work activity. The evaluation team will work with CDSD over the next year to determine the best way to address this issue.

[25] The cost of administering the HEC component of the MAPP program can be quantified because these services are provided by ERI under a separate contract with CDSD. For state fiscal year 2002-03, $120,000 was budgeted for the administration of HEC. This budget covers all aspects of administering the HEC program, including supervisory and administrative support provided by ERI, subcontracts with regional HEC screeners, training costs and all travel expenses associated with the program.

Data

Data for the following analysis come primarily from Medicaid claims data. Two additional data sources are used in this analysis. The Human Services Reporting System (HSRS) is a data collection system for social service and mental health clients, the services they receive, and the funds expended. Data are collected for services provided or purchased by a state or county contract agency, including county departments of human services, social services, community programs, and developmental disabilities services. The Long-Term Support module of HSRS provides long-term care cost data for all persons in Wisconsin covered by the Community Options Program (COP) and Medicaid Home and Community-Based Services waivers. Additional data for earned income are drawn from CARES, or from the MAPP Application database, whichever is more appropriate for the analysis.

Analysis

The first *MAPP Evaluation Annual Report* described data on Medicaid health care expenditures for MAPP program recipients and comparable SSI or disabled adults who were not enrolled in MAPP. The following analysis describes MAPP health care expenditures compared with expenditures for non-MAPP recipients over the first two years of MAPP program implementation, and also describes Human Services Reporting System (HSRS) long-term care costs for MAPP program participants compared with non-MAPP recipients receiving long-term care services under Medicaid Waiver programs.

Major Findings

Major questions and findings described in this section of the report include:

1. Has the average amount paid per person per year for various health care services changed between the first and second years of the MAPP program?

    - Medicaid expenditures per full-year equivalent (FYE) recipient increased significantly for pharmacy[26], and decreased significantly for hospital inpatient services, but did not change significantly for other services.
    - The decline in Medicaid expenditures for hospital inpatient services corresponds to an increase in the share of hospital expenditures paid for by Medicare.
    - The increase in pharmacy expenditures after MAPP enrollment is significantly greater than the increase for comparable MA recipients not enrolled in MAPP.

2. Does the rate of expenditure vary over time, by age, by income, or by MAPP premium level?

    - There is a statistically significant increase in the average rate of expenditure between the first and second year of MAPP program implementation.

[26] Pharmacy expenditures may have increased as a result of "pent-up" demand for prescription drug coverage among MAPP enrollees, or as a result of drug trend, or the rate of change in drug spend over time, which is expected to average 12%-18% over the next three years based on "The Merck-Medco Drug Trend Report, 2001." However, further analysis using an MA comparison group showed that the increase in **total** MAPP expenditures was not due to inflation in drug expenditures alone.

- Rising expenditure rates over time appear to have no systematic (linear) relationship to MAPP recipients' age, income, or premium level.

3. Does the risk-adjusted rate of expenditure increase or decrease after MAPP enrollment, and how does this trend compare with other MA recipients?[27]

    - The rate of expenditure per FYE is lower for MAPP recipients before they enroll in MAPP, and lower still for MAPP recipients with no prior MA enrollment, at the time of MAPP enrollment, compared to a matched sample of non-MAPP MA recipients.
    - The rate of increase in expenditure per FYE for MAPP recipients after MAPP enrollment is higher than the rate of increase for comparable non-MAPP MA recipients.
    - By 14 months after enrollment in MAPP, there is no significant difference in expenditures per FYE for MAPP and comparable non-MAPP MA recipients.

4. Do Long Term Care costs per person vary over time, and how does this trend compare between MAPP participants and other people covered by LTC waivers?

    - There is no significant change in LTC-waiver costs per person per month following enrollment in MAPP.

A detailed discussion of each of these analyses and accompanying findings follows.

Health Care Utilization and Expenditures

Medicaid claims data were analyzed to provide information on the types and costs of services utilized by MAPP participants. MAPP costs and utilization are compared between participants who had Medicaid coverage prior to MAPP enrollment, and those who did not. Finally, health care cost and utilization data are compared between MAPP program participants and a comparison group of similar disabled Medicaid recipients. The comparison group has been matched on key characteristics such as age, gender and illness burden.

Total outlays for health care utilized by MAPP participants were $3.8 million in the first full program year (PY1: beginning 4/1/2000 and ending 3/31/2001) and $10.6 million in the second full program year (PY2: beginning 4/1/2001 and ending 3/31/2002 – current nominal dollars, unadjusted for inflation). As Medicaid is funded by both state and federal governments, after deducting premium revenue from the total service costs, the State can claim federal financial participation of approximately 59% for the remainder of the service costs. Total services costs by category of service are listed in the following table.

[27] By introducing the MA comparison group, inflation across all expenses, including prescription drugs, is accounted for in each anlysis.

Amount Paid by Program Year and *Category of Service*				
Category of Service	**Program Year One**		**Program Year Two**	
	Total Amount Paid	**Percent of Amount Paid**	**Total Amount Paid**	**Percent of Amount Paid**
Inpatient Hospital Services	$325,448	8.50%	$461,886	4.40%
Mental Hospital Services for the Aged	-	0.00%	-	0.00%
SNF/ICF Services for the Aged	-	0.00%	-	0.00%
Inpt. Psych. Facil. Serv. for Indiv. Age 21 & Under	-	0.00%	-	0.00%
ICF Services for Mentally Retarded	-	0.00%	$6,007	0.10%
ICF Services All Other	$11,654	0.30%	-	0.00%
SNF Services	$17,412	0.50%	$22,301	0.20%
Physicians Services	$36,770	1.00%	$67,980	0.60%
Dental Services	$39,014	1.00%	$98,521	0.90%
Other Practitioners Services	$11,960	0.30%	$292,292	2.80%
Outpatient Hospital Services	$85,124	2.20%	$212,658	2.00%
Clinic Services	$111,764	2.90%	$279,425	2.60%
Home Health Services	$257,814	6.70%	$719,872	6.80%
Family Planning Services	$7,334	0.20%	$32,286	0.30%
Lab and X-Ray Services	$33,652	0.90%	$71,661	0.70%
Prescribed Drugs	$1,760,358	45.70%	$5,389,655	50.90%
EPSDT	$112	0.00%	$245	0.00%
Rural Health Clinic Services	$1,038	0.00%	$1,953	0.00%
Other Care	$556,275	14.50%	$1,269,550	12.00%
Capitation Payments (HMO and Buy-In)	$274,606	7.10%	$794,246	7.50%
Institutional Cross-overs	$78,712	2.00%	$247,524	2.30%
Professional Cross-overs	$213,251	5.50%	$596,841	5.60%
CCO	$25,688	0.70%	$13,646	0.10%
Total	**$3,847,987**	**100.00%**	**$10,578,548**	**100.00%**

To determine whether this increase is proportional to program enrollment, each recipient's duration of MAPP program eligibility was measured and converted into a "full year equivalent" (FYE: total days enrolled in MAPP during the PY, divided by 365). When the number of enrollees and duration of their enrollment is accounted for, the total outlay per FYE is $6,000 in PY1 and $6,700 in PY2.

Thus, there does appear to be an increase in health care spending from the first program year to the second program year that cannot be accounted for by the increase in enrollment alone. Some of this increase may be due to "medical inflation", since the "nominal" dollar amounts reported have not been adjusted for possible differences in the purchasing power of health care dollars. Further analysis of pharmacy expenditures (p. 35) and total expenditures (p. 38) using an MA comparison group showed that these costs increase even after accounting for inflation.

To further examine the increase in expenditures per FYE, we compare differences within category of health care service, within age groups, within income groups, and within MAPP

premium groups. The following table shows the comparison of expenditures per FYE within each category of health care service.[28]

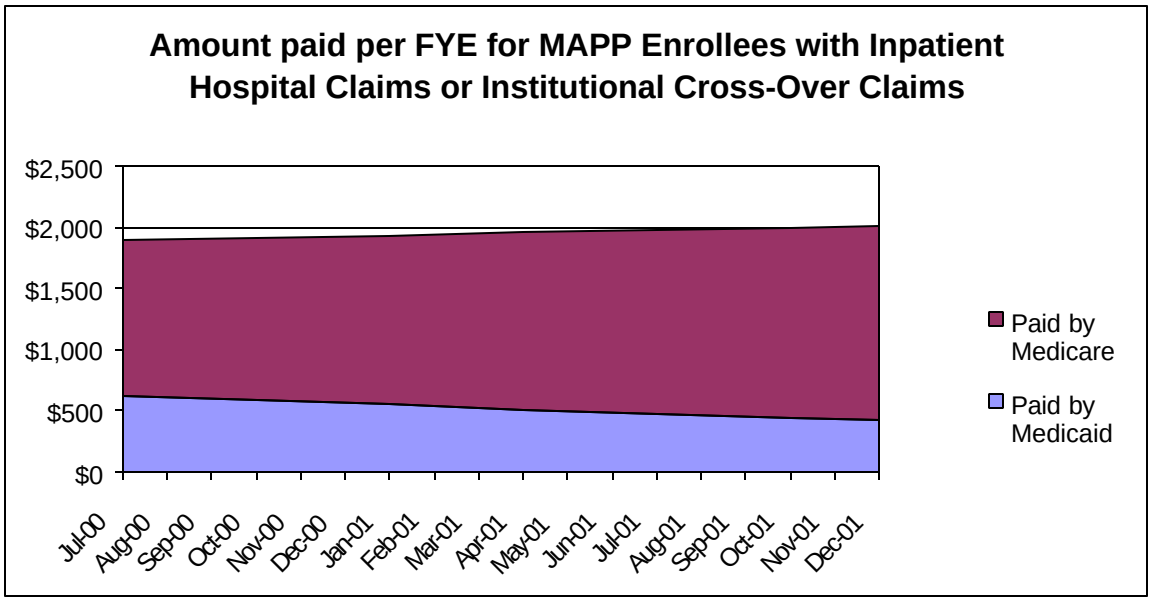
Average Annual MAPP Payments by Program Year and *Category of Service*		
Category of Service	**Program Year One Average Annual Payment Per FYE**	**Program Year Two Average Annual Payment Per FYE**
Inpatient Hospital Services	**$519**	**$293**
Mental Hospital Services for the Aged	-	-
SNF/ICF Services for the Aged	-	-
Inpt. Psych. Facil. Serv. for Indiv. Age 21 & Under	-	-
ICF Services for Mentally Retarded	-	$4
ICF Services All Other	$9	-
SNF Services	$29	$14
Physicians Services	$65	$43
Dental Services	$58	$63
Other Practitioners Services	$17	$185
Outpatient Hospital Services	$166	$135
Clinic Services	$169	$177
Home Health Services	$393	$457
Family Planning Services	$14	$20
Lab and X-Ray Services	$67	$45
Prescribed Drugs	**$2,624**	**$3,420**
EPSDT	-	-
Rural Health Clinic Services	$2	$1
Other Care	$837	$806
Capitation Payments (HMO and Buy-In)	$459	$504
Institutional Cross-overs	$119	$157
Professional Cross-overs	$352	$379
CCO	$31	$9
Total Payments	$3,847,987	$10,578,548
Total FYE	642	1,576
Total Payments/FYE	**$5,998**	**$6,713**

Statistical t-tests on the differences in the table above revealed that only two categories had significantly different average levels of spending in the two years: hospital inpatient services had an average **decrease** of $320 per FYE in PY2, and prescription drugs had an average **increase** of $660 per FYE in PY2, compared with PY1.

Hospital Inpatient Services

One explanation for the decline in the amount Medicaid paid for hospital inpatient expenditures is the increase in Medicare dual-eligibility for MAPP recipients following MAPP enrollment. Prior to MAPP program enrollment, 58% of MAPP recipients had some form of Medicare coverage, which increased to 89% of recipients after MAPP enrollment. The chart below shows that the amount paid by Medicaid for hospital services does decrease over time, but the amount paid by Medicare increases substantially over the same time period.

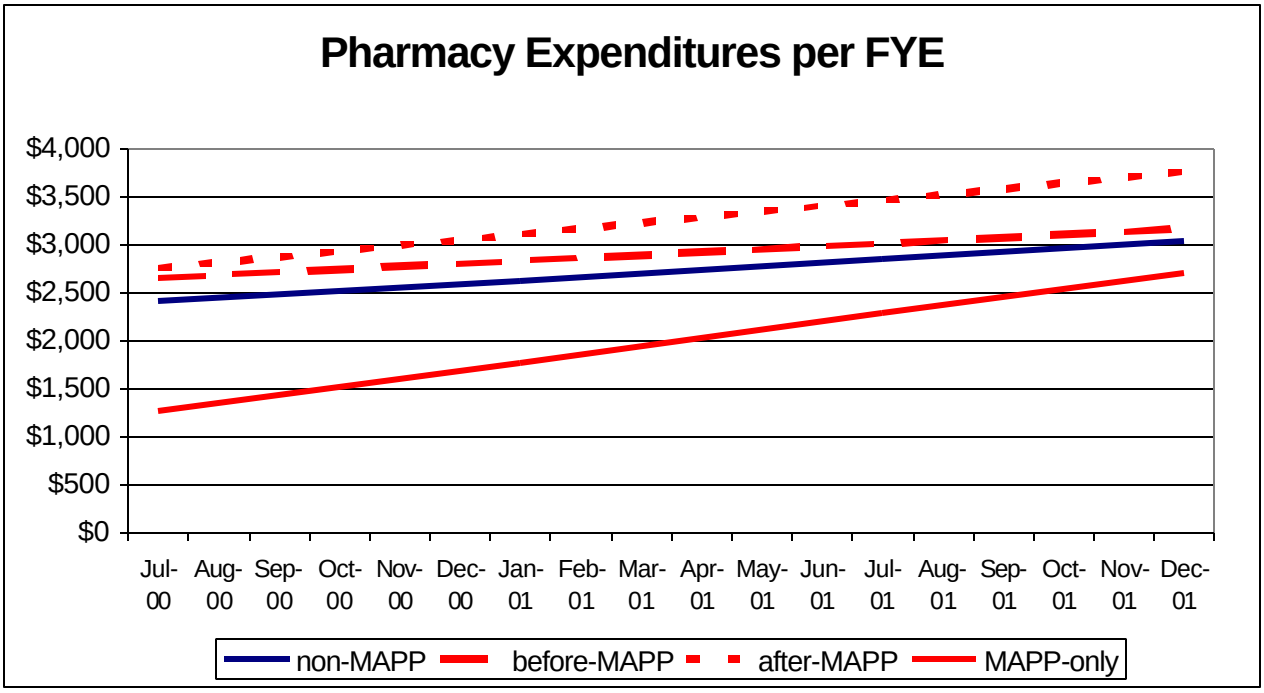
[28] For all tables presented in the Fiscal Analysis, **BOLD** items represent significant findings at the .05 level.



Prescription Drugs

It has been widely observed that Medicaid prescription drug prices are increasing rapidly. This raises the question of whether the observed rate of increase for MAPP enrollees is more or less rapid than the general rate of increase. Therefore, we compared the rate of increase in pharmacy expenditures between MAPP enrollees and a comparable group of MA recipients not enrolled in MAPP.

The figure below shows that prescription drug expenditures increased throughout the period between July 1, 2000 and December 31, 2001. The comparison group ("non-MAPP") and the MAPP enrollees with MA experience – prior to their enrollment in MAPP ("before-MAPP") – have very similar spending levels and trends. The two lines representing post-MAPP enrollment for those with prior MA experience ("after-MAPP") and those with no prior MA experience ("MAPP-only") show a significantly higher rate of increase than either the comparison group or the MAPP group with prior MA experience before they enrolled. Therefore, it appears that enrollment in the MAPP program significantly increases the rate of prescription drug expenditure, over and above what would be expected without MAPP program enrollment.



MAPP Expenditure Variation by Age, Income, and Premium Level

The increase in spending per FYE was fairly evenly distributed by age group, as shown in the following table. Insufficient data were available to test significance for MAPP participants under the age of 20. Recipients aged 50 through 74 did not have significantly higher expenditures in PY2, but those aged 20 to 49, or 75 years and older, did have significantly higher expenditures in the second full year of MAPP implementation.

Average Annual MAPP Payments
by Program Year and *Age Group*

Age Group	Program Year One Average Annual Payment Per FYE	Program Year Two Average Annual Payment Per FYE
16-19	$1,848	$1,288
20-29	**$4,835**	**$6,977**
30-39	**$6,563**	**$8,091**
40-49	**$5,602**	**$6,313**
50-64	$6,553	$6,862
65-74	$4,435	$3,497
75+	**$1,347**	**$2,953**

Looking at expenditure increases within levels of income in the following table[29], no clear pattern emerges. Expenditures per FYE are significantly higher between PY1 and PY2 for those with no reported monthly earned income. Expenses among this group rose over $1,000 from

[29] Earned income data were obtained through CARES or the MAPP application database for recipients who disenrolled from MAPP prior to automation in CARES . If the data sources provided different earned income amounts, the most current earned income figure was used.

PY1 to PY2. Participants earning $101 to $250, and $501 to $1,000 in monthly income also exhibited significant increases from PY1 to PY2. None of the groups have lower expenditures between PY1 and PY2, but there is no clear linear association between income level and changes in spending from one year to the next.

Average Annual MAPP Payments
by Program Year and *Earned Income*

Income	Program Year One Average Annual Payment Per FYE	Program Year Two Average Annual Payment Per FYE
$0	**$5,986**	**$7,091**
$ 1-$100	$7,672	$7,718
$ 101-$250	**$6,631**	**$7,340**
$ 251-$500	$5,239	$6,259
$ 501-$1000	**$4,962**	**$5,179**
$1001-$5000	$5,832	$8,390

Finally, the changes in expenditures per FYE from PY1 to PY2 are compared by level of MAPP premium in the table below. As with age and income levels, there is no clear association between premium levels and expenditure increases. Expenditures increased at all premium levels, except those with premiums of $50-$75 and $600-plus.

Average Annual MAPP Payments
by Program Year and *Premium*

Premium	Program Year One Average Annual Payment Per FYE	Program Year Two Average Annual Payment Per FYE
$0	**$5,834**	**$6,583**
$25	**$7,414**	**$8,675**
$ 50-$75	$4,556	$6,146
$100-$175	**$5,359**	**$7,396**
$200-$575	**$6,744**	**$7,418**
$600+	$11,060	$7,657

The tables above present the distribution of MAPP health care expenditures **adjusted for differences in numbers of enrollees and duration of enrollment in the first and second years of MAPP**. Statistical comparisons show that there is no clear association between increased spending and age group, income level, or premium level. There is a clear increase in spending associated with only one category of service; prescription drug spending (per full-year equivalent) is higher in the second year than in the first, and this difference accounts for the over-all increase in total health care spending per FYE between the first and second year of the MAPP program.

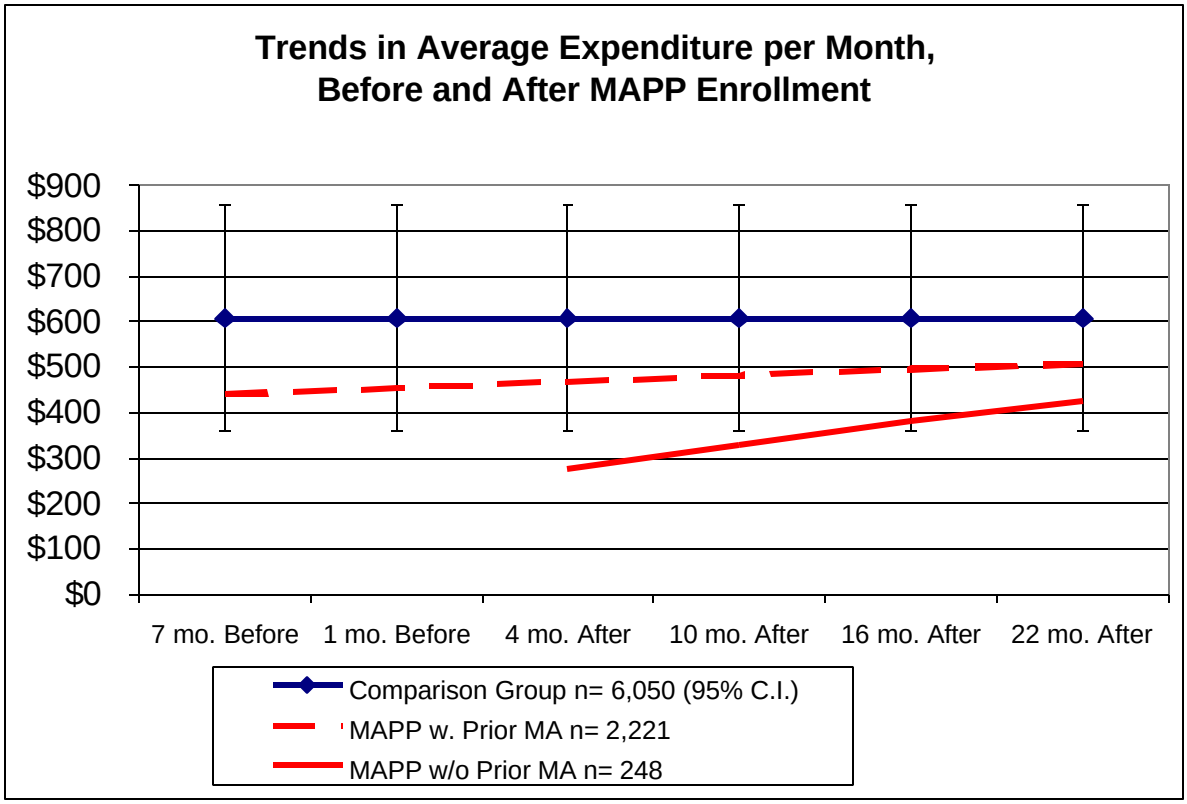
Change in Expenditures Before and After MAPP Enrollment

The foregoing analysis of changes in average expenditures from the first to second MAPP program year has shown a significant increase of approximately 10%, due primarily to increased spending for prescription drugs. This year-to-year comparison of aggregate spending can identify an overall trend, but a more robust method is required to determine whether participation in the MAPP program has any independent effect on recipient health care spending. To isolate the effect of MAPP enrollment on spending and control for other possible confounding factors, the evaluators constructed a "pre/post, control-group" quasi-experimental design. This allowed us to compare the change in spending for MAPP recipients to the change in spending for a group of similar recipients who have never participated in MAPP, so that any observed difference would be attributable solely to participation in the MAPP program, all other things being equal.

The control group is a random sample of Medicaid fee-for-service recipients with the same profile of medical status group, age, sex, and geographic location as the population of MAPP recipients. For both MAPP and non-MAPP recipients, diagnosis information was collected and grouped into a co-morbidity related illness burden index using the Chronic Illness and Disability Payment System (CDPS) software developed at the University of California at San Diego. These variables were then held "equal" using statistical control; a multiple-regression equation was computed for monthly expenditures per enrollee, controlling for age, sex, and illness burden index.

MAPP participants were divided into two groups, those with any prior Medicaid experience and those with no prior experience, as to control for a "composition effect" that was noted in the first annual report. MAPP participants with no prior MA experience tended to have lower average expenditures than those who have been enrolled in Medicaid prior to MAPP enrollment. Therefore, the "composition" of the population may skew the findings (i.e., the greater the number of participants with prior Medicaid, the greater the costs of the program). Eligibility and spending for these recipients was measured for each month from January 1999 through December 2001. Each recipient in each month was classified according to whether their spending took place before or after their (first) MAPP enrollment date. The difference in spending **per eligible per month** was then calculated by subtracting control group expenditures from MAPP participant expenditures (adjusted for age, sex, and illness burden).

The following graph shows the level and rate of change in expenditures per eligible recipient per month for these three groups of individuals. Observed is a rising trend in expenditures per month following MAPP enrollment, which converges to a level of spending that is not significantly different from the comparison group fourteen months after enrollment in the MAPP program.



Generally speaking, this graph shows that MAPP recipients **with no** prior MA experience had significantly lower expenditures at the time of their MAPP enrollment and more rapidly increasing expenditures over time, relative to the MA comparison group. MAPP recipients **with** prior MA experience had slightly lower expenditures upon MAPP enrollment and gradually increasing expenditures thereafter, relative to the non-MAPP comparison group. Neither group of MAPP enrollees had a significantly different level of spending compared to non-MAPP peers after approximately fourteen months in the MAPP program.

As discussed above, the faster rate of increase in expenditures for MAPP enrollees is primarily due to increased prescription drug expenditures subsequent to MAPP enrollment. As noted in the first annual report, this increase may reflect "pent-up demand." If these individuals did not have prior access to health care coverage, especially coverage of prescription drug benefits, then they may be catching up on their health care needs following enrollment in MAPP. The data are consistent with the hypothesis that MAPP provides access to health care services for an otherwise underserved population.

MAPP Program Effects on Cost-Shifting

New in this annual report is an analysis of costs for MAPP participants who were previously or are concurrently covered by other health insurance programs: long-term care costs of Medicaid waiver programs, Medicare dual-eligibility, and third-party liability[30].

[30] Third-party liability refers to insurance coverage through sources other than Medicaid or Medicare, such as employer or private policies.

Enrollment in the MAPP program is associated with a significant shift away from third-party liability. Of the 2,797 MAPP participants who had enrolled before April 1, 2002, 13% (376) had some form of health insurance from a third party (not including Medicare) when they enrolled. Of those 376 with third-party liability, 64% (242) had dropped third party coverage by April of 2002, an average of 7 months (median of 5 months) after MAPP enrollment. Because this number includes individuals who were observed for less than a full year after enrollment, it may under-estimate the rate of attrition from third-party coverage.

In contrast to the decline in third-party coverage, dual-eligibility for Medicaid and Medicare actually increased from 58% of MAPP recipients prior to enrollment to 89% of recipients after MAPP enrollment. This may be due in small part to aging, but may also result from enhanced coordination of benefits spurred by increased attention to eligibility requirements during the MAPP program enrollment process. As discussed earlier, the rising proportion of Medicare dual-eligible MAPP enrollees is responsible for a shift of hospital inpatient expenditures from Medicaid to Medicare.

Finally, the MAPP program appears to have little effect on cost-shifting of long-term care costs that would otherwise be covered under various Medicaid waiver programs. Long-term care cost data for all Wisconsin residents covered by Wisconsin Home and Community Based Waver Services (HCBWS) such as CIP 1A, CIP II, COP-waiver, CIP 1B, CSLA, BIW, and Family Care was analyzed. We were able to identify which of these people have also enrolled in the MAPP program. The table below shows the results of this analysis.

Average LTC-Waiver Costs per Person per Month
By Participant Group[31]

Waiver	non-MAPP	before-MAPP	after-MAPP	MAPP-only
COP-R	$556	$770	$914	$446
	37,150	205	121	20
COP-W	$757	$642	$719	$517
	16,919	32	24	5
OTHER	$2,157	$2,529	$2,300	$1,511
	19,246	261	194	15

This table shows that prior to enrollment, MAPP recipients have generally higher LTC costs than other people in waiver programs. After MAPP enrollment, LTC costs for MAPP recipients are generally about the same as costs for other people in waiver programs, while MAPP recipients with no prior MA experience tend to have lower LTC-waiver costs per person per month. A statistical test of the difference in LTC-waiver costs per person per month for 171 MAPP recipients who were in the waiver programs both before and after their MAPP enrollment

[31] Data in this table includes MAPP program participants compared to all other people covered by LTC-waiver programs between January 1, 1999 and December 31, 2001. Count of persons in each category is **not unduplicated**; persons may be enrolled in more than one waiver program during the period.

showed that there is no statistically significant change in LTC-waiver costs per person following MAPP enrollment. The table also indicates that the number of people participating in waiver programs tends to decline after MAPP enrollment. This aggregate result calls for confirmation by a future investigation of program switching and waiver attrition at the individual level of analysis.

Conclusions

This fiscal evaluation has monitored the effects of MAPP on State and Federal Medicaid funding and measured its impact on locally funded long-term care services. The principal findings are:

- MAPP program spending per full-year equivalent enrollee increased about 10% from the first to second program year, due primarily to increased prescription drug spending.

- No systematic program effect on spending per enrollee was detected, although there is a trend toward increased spending post-MAPP enrollment possibly due to pent-up demand in the population of MAPP enrollees, for prescription drugs in particular.

- Third-party liability declined, and dual Medicare/Medicaid eligibility increased subsequent to MAPP enrollment.

- Long-term care costs carried by waiver programs for MAPP enrollees did not change significantly subsequent to MAPP enrollment.

VI. Process Evaluation

The purpose of the Process Evaluation is to determine whether MAPP was implemented equitably across the State and to evaluate whether the program, as currently designed, is efficient and effective. As previously discussed, the recipient surveys included questions intended to provide information on the enrollment process and the administration of the program from the recipient's point of view. In addition a survey of county Economic Support (ES) workers was conducted to provide insight into the implementation and administration of the program from the counties' point of view[32].

Of the 532 ES workers identified by regional supervisors, 173 returned the ES Worker Survey, generating a response rate of 32.5%. Survey respondents represent 53 of Wisconsin's 72 counties (72%). On average, respondents have been employed as ES workers for more than 11 years; averaging over 15 months experience in conducting MAPP eligibility determinations. The average respondent had completed approximately eight MAPP eligibility determinations. The average time spent conducting MAPP eligibility determinations was just under four percent of the worker's total work time.

ES workers were asked a series of questions designed to measure their knowledge of the MAPP application process and eligibility criteria. Respondents were also asked to evaluate the success of MAPP in meeting its goals. In addition to the quantitative feedback gathered by the survey, extensive qualitative information was also collected. Respondents were provided the opportunity to comment further on their ratings for several questions. Respondents provided comments regarding the MAPP eligibility process, the effectiveness of the program, the application process, training, the premium structure, and members of the community who are not being helped by MAPP.

In year one, the Process Evaluation was based on information collected through a number of informal venues, such as key informant interviews, and through analysis of administrative data. That evaluation resulted in the identification of a number of process issues related to the state and county administration of MAPP. This section of the report will summarize the year one findings and subsequent actions taken by the State to address those issues, in addition to providing a summary of selected findings[33] from the recipient and ES worker surveys.

State and County Administration Issues

MAPP eligibility was not automated on CARES when the program was first implemented because sufficient resources were not available at that time. Lack of automation caused numerous problems with enrollment and accurate record keeping because county agencies were not consistently submitting the MAPP eligibility applications to CDSD. A review of the submitted applications by the evaluators for the first Annual Report identified a significant

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[32] The ES Worker Survey was administered in November of 2001. It is important to note that all ES Worker Surveys were completed by December 21, 2001, prior to the automation of MAPP on CARES. As a result, many of the survey comments focus on the difficulty of determining MAPP eligibility without access to CARES. While many of the issues related to CARES have been resolved with automation, survey respondents addressed numerous other issues associated with MAPP that were ***not resolved*** by automation.

33 A separate comprehensive report on the ES Worker Survey was provided to CDSD in September 2002.

number of incomplete applications or applications containing errors. Errors found on the applications included:

- Missing forms
- Missing dates of birth
- Missing filing dates
- Incorrect or missing Social Security numbers
- Incorrect income for premium calculations
- Inconsistent information between worksheets

Analysis of premium worksheets indicated that some county workers were calculating premium amounts incorrectly. In the majority of the cases, the worker was testing the applicant for premium liability using his/her adjusted family income, rather than their individual gross monthly income. Approximately 10% of the returned applications exhibited this error. As a result of this error, there was a chance that an individual would have been incorrectly categorized as eligible for MAPP with no premium, when in fact, a premium was required. This error had been made by 27 different certifying agencies.

Subsequent to the first Annual Report, CDSD in conjunction with the Bureau of Health Care Eligibility (BHCE) drafted and issued an ES Operations Memo to address the low percentage of MAPP applications that were being returned by the counties. This intervention was very effective and by November 2001, the return rate had improved to 84%. The submission rate remained relatively stable until CARES was automated in January 2002 and submissions were no longer necessary. The errors which resulted from "human error" in the manual determination process, such as incorrect premium calculations and missing data have been resolved by the automation of the MAPP enrollment process in CARES.

Premium Structure

The first year Annual Report identified concerns about the equitability of the structure of the premium calculation formula. The MAPP definition of income for premiums treats earned and unearned income differently. One's premium liability does not increase proportionately to one's increase in total income. Rather, it increases disproportionately with one's increase in unearned income as a result of the formula. MAPP participants are required to contribute 3% of their adjusted earned income toward their premium, while they are required to contribute 100% of their adjusted unearned income if their total income is above 150% of the Federal Poverty Level (FPL). The effect of this disparity is that individuals with the same total income, but with different ratios of earned and unearned income could be paying significantly different premiums. While this effect was intended by program developers to provide a strong work incentive, it has since been identified as inequitable by a variety of program stakeholders.

In the first year of the evaluation, premium payment and earnings data were analyzed to assess the efficacy of the premium structure in terms of providing work incentives. This analysis was repeated for this report. The following table provides the median earned and unearned income for four groups of recipients: (1) individuals with no premium liability; (2) $25 premium payers; (3) $50-$100 premium payers; and (4) individuals paying premiums in excess of $100.

	Number of Enrollees	Median Earned Monthly Income	Median Unearned Monthly Income
No Premium Liability[34]	2,382	$150	$714
$25 Premium	90	$1,014	$616
$50-$100 Premium	109	$581	$714
Over $100 Premium	201	$452	$895
Total	**2,782**	**$205**	**$724**

This year's analysis suggests that the premium structure is effective in providing work incentives. Individuals with high levels of earned income are paying lower premiums than their lower-earned income counterparts. However, similar to last year's findings this analysis raises questions about the presumed relationship of earned and unearned income for MAPP participants. The premium structure was predicated on the assumption that as MAPP participants increased their earnings there would be corresponding reductions of unearned income. This analysis suggests that there may not be such a direct relationship for some of the MAPP recipients. Because the premium structure has not changed, it is still possible to have recipients with very similar total incomes paying very different premiums. For example, there is only a difference of $52 in total income between the average $50-$100 premium payer and the over $100 payer.

Of note is that among MAPP survey respondents who were paying a premium, the majority felt that the premiums were at least "somewhat" affordable. Eighty-one percent of the initial and follow-up survey respondents felt that their premiums were at least "somewhat" affordable.

The ES worker survey included a number of open-ended questions that generated feedback about the premium structure. Data collected on the program's premium structure suggests that workers have identified individuals who "need MAPP", but are unable to participate in the program because the premiums would be too costly. The majority of respondents who commented on the premium structure indicated that the premiums were too high. In addition, approximately 22% of all comments related to the efficacy of MAPP related to concerns about the high cost of the MAPP premiums. Workers were also concerned about the "cliff effect" of the premium structure. For example, with a change of $.01 in income, an individual can go from having no premium liability to having a premium of a few hundred dollars, depending upon the individual's monthly unearned income.

CDSD has responded to this concern by convening a number of workgroups to explore possible alternative premium structures that would be viewed as more equitable, while still providing the necessary work incentives. As part of this evaluation, CDSD may want to take into consideration ES worker suggestions for simplifying the formula, and also to explore options for minimizing the "cliff effect" and the possibility of prohibitively high premiums. As they explore possible alternatives, CDSD may want to consider providing additional information on the rationale of the

[34] All data for this table were taken from the July 2002 CARES data extract.

current premium structure to ES workers so that they better understand the rationale for the formula and can explain it to prospective applicants appropriately.

Independence Accounts

Very few independence accounts were registered during the first year of the evaluation. Only 1% of participants had registered accounts, which suggests one of three things: (1) participants are not taking advantage of this program benefit; (2) participants are not aware of this program benefit; and/or (3) ES workers were not documenting these accounts.

Independence Accounts continue to be an underutilized benefit. As of July 2002, CARES reports 54 active Independence Accounts (IA) representing 44 program participants. A zero balance was reported for 19 accounts (43% of all accounts). Considering that 43% of the accounts report a zero balance there does not appear to be any increase in savings toward independence. There are, however, a handful of individuals who have used this benefit to set aside significant assets. Six accounts have a registered balance greater than or equal to $10,000. Three of these accounts are IRAs, one is a savings certificate, one a credit union account and the last is a tax shelter. Eight enrollees reported a balance of $10,000 or more (an individual may register more than one account).

ES workers are supposed to enter IA data if it is available; however, CARES does not make it mandatory in order to complete the eligibility determination. Therefore, it is still unclear as to which one or more of the three aforementioned reasons is the cause of the low number of accounts.

Milwaukee County Enrollment

As discussed in the initial Annual Report, given Milwaukee County's proportion of the disability-related Medicaid caseload, the county's MAPP enrollment was lower than expected. At the time of the first Annual Report, Dane County had certified 2.5 times the number of MAPP recipients as Milwaukee County, but Milwaukee County had more than five times the number of disability-related Medicaid eligibles. Anecdotal information gathered from Pathways to Independence Benefits Specialists in June 2001 also reinforced the assumption that there were some challenges with program implementation in Milwaukee County.

Problems with MAPP enrollment in Milwaukee County appear to be an ongoing issue. A HEC Regional Screener in Milwaukee recounted the following example of difficulty with the HEC/MAPP enrollment process in Milwaukee County as part of her January 2002-March 2002 quarterly report to Employment Resources, Inc. (ERI), the administrator of the HEC program.

> *During this past quarter, one individual was screened by IndependenceFirst and approved by the Department of Health and Family Services (DHFS) for the Health and Employment Counseling (HEC) program. This individual, Ruth S., encountered numerous problems with Milwaukee County throughout the application process. Ruth receives Social Security Disability Insurance (SSDI) benefits and had been trying to file an application for the Medicaid Purchase Plan (MAPP) since December. She was not working and wanted to access the HEC program. Ruth had gone to the county to apply several times, she waited 3*

> *½ hours on one occasion only to be told that the person who takes the applications for MAPP was not in. Ruth continued to try to apply and was told she needed to apply through her Food Stamp worker. Ruth's Food Stamp worker took her application but informed her that the application process for MAPP takes 6-8 weeks and he had been told by his supervisor that he could only work on MAPP applications one Monday a month. Several weeks later Ruth received a letter from Milwaukee County stating that she was eligible for MAPP, despite the fact that she was not working and had not yet been screened for HEC. On February 22nd, almost 3 months after starting the application process, Ruth legitimately became enrolled in the HEC program.*

Subsequent to the first annual report, low enrollment in Milwaukee County was discussed with the Bureau of Health Care Eligibility (BHCE) and Milwaukee County Department of Social Services (DSS) to identify possible training and follow-up plans. In addition, ongoing outreach in Milwaukee County was conducted by regional HEC screeners as described below.

Hoping to address the many enrollment issues in Milwaukee County, HEC Regional Screeners conducted four formal presentations on HEC/MAPP in the Milwaukee area during the period January through March 2002. Presentations were conducted for the following groups/individuals:

- Milwaukee County Community Employment Services Group, consisting of representatives from all agencies who contract with Milwaukee County for employment service
- Director of Industrial Services at Curative Care Network, which hires a number of individuals with disabilities who are not enrolled in any services at Curative, but may benefit from MAPP
- Froedtert Hospital Spinal Cord Injury Center Inpatient and Outpatient Support Group
- Milwaukee County BadgerCare Coordination Group

According to Deb Falk-Palec, the HEC Regional Screener from Curative Care Network in Milwaukee County, the Milwaukee County BadgerCare Coordination Group presentation was the most successful in terms of addressing the enrollment issues in Milwaukee County. The presentation resulted in a meeting between the Milwaukee area HEC screeners and staff from the Milwaukee County Financial Assistance Division and the Milwaukee CARES Coordinator. Through these meetings, the screeners were able to focus on two goals: (1) addressing the training needs of their staff; and (2) identifying specific individuals in the county who can focus on the HEC/MAPP process. To address these goals, the screeners arranged an additional HEC/MAPP presentation to approximately 50 managers and supervisors in the Financial Assistance Division and identified a few Milwaukee County workers who can specialize in HEC/MAPP on April 23, 2002.

While it is too soon to measure the full effects of these efforts, there has been an increase in Milwaukee County MAPP enrollment. As a percentage of the total MAPP population, Milwaukee County recipients increased from 4.8% to 7.9%, a 63% increase, from year one to year two of the evaluation; however, Dane County is still enrolling a higher percentage of MAPP recipients than Milwaukee County (almost 1.5 times as many).

Understanding of MAPP Policies and Procedures

The first Annual Report identified a number of instances where conflicting information on MAPP policies and procedures was provided to potential applicants, program participants or ES workers. For example, the MAPP handbook and the MAPP Consumer Guide provided different definitions of IRWEs. Approximately 63% of respondents to the Initial Survey learned about MAPP from a county source, which speaks to the critical role that ES workers play in the administration of MAPP.

The ES worker survey conducted in the last year provided better insight into how this conflicting information affected the administration of the program at the local level.

In general, ES workers did not feel they had done enough MAPP eligibility determinations to become proficient. A fair number of workers also indicated that they did not know how to determine financial eligibility for MAPP or how to determine if a person's disability qualifies them for MAPP. However, the majority reported that if they had a question about MAPP eligibility they knew who to ask. When asked to rate their understanding of the MAPP eligibility criteria compared to other public assistance programs for which they determine eligibility, over one-third of the individuals rated their understanding of the eligibility criteria as worse than other programs.

Even though many of the eligibility determination functions are now automated on CARES, there is still a need for additional MAPP training so that ES workers are able to explain program requirements and policies to prospective applicants and program participants. Only 26.6% of the survey respondents agreed that they have had enough training on the MAPP program. In addition, when asked to identify why MAPP may not be meeting its goals, a number of workers commented on the quality of MAPP training for ES workers. More than one-third rated the quality of MAPP training as worse than training for other programs for which they determine eligibility.

An area where there appears to be a particular need for clarification and training relates to the MAPP program's work requirement. Findings from the survey suggest that the work requirement has been interpreted a number of different ways and is confusing for ES workers. Some workers feel that the work requirements are too burdensome for the target population, while others find the requirement to be meaningless.

> *Most people I have approached regarding this program are unable or unwilling to work even the minimum hours to meet eligibility.*
>
> *Wisconsin's medical assistance programs are so lenient when it comes to family medical assistance. The disabled, the population that needs medical assistance the most, are subjected to participating in meaningless and inconsequential "work" to qualify for MAPP – too many rules and hoops to jump through for this group.*
>
> *I believe MAPP has been very helpful. Most of the customers I have on MAPP are not able to do a lot of work so it has been of great benefit to them as the majority would otherwise have MA deductibles.*

The survey clearly identifies a need to better define what constitutes "work" for MAPP program eligibility and to disseminate this definition to ES workers. As MAPP was conceived as a "work-incentive" program, the ability to define "work" and to communicate the definition to program applicants and participants is imperative for the program's success. CDSD is currently working to develop a suitable definition of work that fits the program's needs and also adheres to federal guidelines.

Waiver Status

CIP IA, CIP IB and CIP II are community based waiver programs that provide a federal MA waiver and federal funding to de-institutionalize many of the state's developmentally disabled, physically disabled and elderly residents. COP-R is a similar program that provides additional **state** resources to move these individuals out of institutions and into the community. COP-R **is not** an MA waiver program. COP-W (COP-Waiver), however, **is** an MA waiver program that supports the community integration of the physically disabled and elderly with federal funding.

A small percentage of MAPP enrollees are participating in a Home and Community Based Waiver (HCBW) long-term care waiver program while on MAPP. In December 2001, 13% (214) of the MAPP participants were matched to HSRS waiver data; the same percentage that was matched in December 2000. Approximately 40% of these individuals were participating in the Community Integration Program (CIP) 1B (locally matched slots). Another 21% of the MAPP community based program participants were enrolled in the Community Options Program (COP-R)[35]. Less than 7% of the individuals were participating in the COP waiver (COP-W) program.

COP-R is supported entirely with state funds and there are a number of restrictions on how these funds can be used for individuals who are also eligible for community based waiver programs, such as COP-W and CIP. The ability to convert individuals from COP-R to COP-W is a matter of fiscal importance to the state because COP-W services are eligible for federal Medicaid match, while COP-R services are not. It was expected that through MAPP eligibility requirements some COP-R participants would be eligible for and converted to the COP-W program, but findings from the first year of the evaluation suggested that these conversions may not have occurred.

The number of MAPP COP-R participants in August 2002 (149) versus COP-W participants (47) continues to raise questions about why there continue to be more MAPP recipients participating in COP-R than COP-W. There are a number of reasons that counties may not be able to or may not want to complete these conversions. For example, COP-R participants who are chronically mentally ill or who have Alzheimer's disease are not eligible for Medicaid waiver services, including COP-W. There are also specific services available under COP-R that are not available under COP-W. CDSD has been working over the last year to obtain MAPP participant diagnoses data from the DHFS Disability Determination Bureau (DDB), which would provide additional insight regarding the COP-R/MAPP participants. However, this data was not yet available at the time of this analysis. It is hoped that diagnoses information for the majority of MAPP participants will become available during the final year of the evaluation, to allow a better

[35] A number of MAPP enrollees were eligible for more than one waiver in a given month.

analysis of this and other issues. *Attachments K and L* in section VIII Appendix provides additional detail on the waiver status of MAPP enrollees.

HEC Program Improvements

In the first year of the evaluation, it was discovered that a significant number of MAPP participants reported $0 in earned income, but were not enrolled in the HEC program. In order to be eligible for MAPP an individual must be working or enrolled in the HEC program. The high number of individuals who appeared to be doing neither raised concerns about the effectiveness of the HEC program. As of July 2002, there were still a significant number of individuals (206) who report $0 income, but do not participate in HEC.

CDSD has been able to identify a number of HEC program issues that contributed to the low number of enrollments, including:

- HEC screeners have full-time duties with their employers and do not have a strong identification with the program.
- Insubstantial and ineffective marketing support for MAPP or HEC
- Limited outreach to the disability community

In addition to the reasons cited above, the majority of the screeners had only a cursory understanding of benefits analysis and benefits planning as they related to individuals with disabilities. Also, as unpaid assistants, the screeners had not been asked to serve consumers that were not clients of their agencies or to engage in HEC program outreach.

CDSD has taken a number of steps to improve the effectiveness of HEC. For example, seven new .2 FTE Regional HEC Screeners were hired and a Statewide HEC Coordinator employed by Employment Resources, Inc. (ERI) was assigned. The initial HEC screeners were allowed to continue to participate in the HEC screening process in year two, acting as HEC liaisons. Unlike many of the initial HEC screeners, all of the new Regional Screeners have experience with disability benefits issues, benefits analysis and counseling, service and supports available to disabled consumers, and familiarity with disability employment barriers.

A considerable amount of effort was also directed toward improving outreach for HEC in 2002. ERI staff presented information on HEC and MAPP to new Pathways to Independence Benefits Counselors and Family Care Disability Benefits Specialists during a nine day benefits counseling training in February. Outreach was also conducted through the Bureau of Community Mental Health's monthly teleconference to the Wisconsin Public Psychiatry Network on January 24, 2002. Outreach efforts during the teleconference focused on work incentives benefits counseling and general HEC information. Information on HEC was distributed to over 72 participants prior to the teleconference. However, some HEC screeners have reported that they are still having difficulty finding the necessary time to promote HEC because they are kept busy answering questions about MAPP.

Other information collected in year two of the evaluation suggests there is additional room for improvement with the administration and coordination of the HEC program According to Amy Judy, Statewide HEC Coordinator reporting in the HEC quarterly report for January – March,

2002, these efforts have been somewhat effective in increasing the efficacy of HEC. However, ERI reports that they still receive a large number of inappropriate referrals. Several referrals consisted of individuals who did not want to return to work, but who were told by their Economic Support contact that they could access MAPP through HEC. According to the January through March, 2002 quarterly report prepared by the Coordinator, individuals referred to HEC have not received a disability determination, a pre-requisite to HEC participation, are not interested in work, or work is not appropriate alternative for the individual.

The HEC program would also benefit from an improved definition of work. A LaCrosse area Regional Screener indicated that she has been told a number of times that several agencies are "helping people get at least an hour or two of work a month" so that they can avoid enrollment in HEC, which would likely require the achievement of more substantial work within the nine-month limit.

Although communication between the HEC Regional Screeners, economic support staff, state staff and other community support staff has increased with the modifications to HEC, several communication issues remain. For instance, many ES workers do not know who to contact with questions regarding MAPP and therefore they utilize HEC Regional Screeners as de facto "MAPP" staff. This in turn reduces the amount of time the regional screeners can commit to administering HEC. Other areas in need of continued monitoring and improvement include general MAPP/HEC eligibility criteria, access to MAPP/HEC enrollment, the role of the Regional Screeners in promoting MAPP, and how working affects enrollees' other benefits.

The HEC Regional Screeners have reported that when they go out into the community to talk about HEC they encounter considerable interest in the program, but a lack of knowledge about how to use the benefit. Common questions, included:

- How does a worker refer a potential consumer to the HEC Regional Screener?
- How long will the enrollment process take?
- How will the worker know when/if the consumer is approved for HEC?
- Will the worker receive a copy of the acceptance letter?
- How to track the consumer during the duration of his/her HEC enrollment?
- How to verify that the consumer has secured employment?
- Who is responsible for tracking and recording employment for participants?

Hopefully, getting these questions answered by the HEC screeners will result in better referrals and subsequent enrollments in the next year.

Program Outreach

A new issue related to the effectiveness of the MAPP program was brought to light by the ES worker survey – the ability of the program to reach "those who need it". ES workers were asked to rate MAPP as it relates to other programs for which they determine eligibility on a number of other criteria. In general, ES workers view MAPP as being on par or worse than other programs for which they determine eligibility. Fewer than 15% of respondents rated MAPP as better than other programs on any of the program elements listed on the survey. Specific areas where MAPP rated poorly included: ES worker training and the quality of program outreach.

Almost 49% of the respondents rated MAPP as worse than other programs in terms of its ability to identify and inform people who may be eligible for the program. The HEC Regional Screeners also reported hearing from ES workers that lack of available information on HEC is a major obstacle to fully understanding and implementing MAPP accurately and efficiently. ES workers were able to provide a number of specific strategies for conducting successful outreach, such as targeting outreach to professionals who routinely interface with the target population.

The survey also included a number of questions asking the ES workers to rate the program's effectiveness. The vast majority (over 72%) of the workers agreed that MAPP is helping people with income and assets too high to qualify for Medicaid. However, only 49% indicated that MAPP is "helping those who need it." This suggests that ES workers believe that MAPP does help a particular subset of the disabled population – those with income and assets too high to qualify for Medicaid - but that there are other individuals who need a program such as MAPP who are either not eligible or not enrolled.

Overall, the survey indicates that ES workers are unsure of the success of the MAPP program in meeting its goals. Forty-three percent of respondents were neutral in their assessment of MAPP meeting its goals, while 44% felt that MAPP was successful at meeting its goals. Very few respondents (8.4%) indicated that MAPP is failing to meet its goals.

Recipient Perspective

The recipient survey also provided additional information on the effectiveness of the administration of MAPP. Over 75% of the respondents to the Initial Survey agreed or strongly agreed that enrolling in MAPP was easy and, in general, MAPP recipients' understanding of the program increased after enrolling in the program. However, satisfaction with the services provided by the ES worker appear to diminish over time. At enrollment, 77% of respondents felt that their eligibility worker spent enough time with them, whereas only 64% of the follow-up respondents felt this way. More importantly, only 78% of follow-up respondents felt that they were treated with respect and dignity by their eligibility worker, compared to 89% of the initial respondents. Eligibility staff were also seen as less helpful by follow-up respondents.

Also of note is that recipients' understanding of their financial options under MAPP appears to diminish over time. Over 57% of initial respondents reported fully understanding their financial options under MAPP. In contrast, only 49% of follow-up recipients reported understanding their financial options under MAPP. It may be that once a recipient begins accessing services through MAPP, the policies and procedures appear more complex, causing confusion or difficulty with the program and/or the eligibility workers.

Respondents to each survey were given an opportunity to provide additional feedback on their experiences with MAPP by responding to several open-ended questions. A total of 218 comments were collected. In general, most respondents appreciate the program; however, there still appears to be significant confusion regarding MAPP eligibility, enrollment, benefits and general program information. A significant number of comments suggest that the recipients are still not clear on what MAPP is or why they are enrolled in the program. For example, one comment stated, "I do not really understand the program. My social worker just told me I would

qualify for this new program which would mean she would not have to review me again until next June." Or, "…MAPP worker has not explained how anything works or what can be expected. Guardian was just handed pamphlets and participant was not even spoken to…" In addition, while the majority of MAPP participants are satisfied with the time spent with them by their county worker, open ended comments suggest that not all workers are effectively conveying program policies and options to potential enrollees and current participants

Updated training sessions are recommended to clarify the original intent of MAPP, as well as specific program policies where there is considerable confusion among the workers. In an open-ended question regarding training needs, almost 28% of the workers answering the question indicated that they would like refresher training. The survey also suggests that training sessions that incorporate mock eligibility determinations and focus on uncommon cases would be effective and appreciated. Updating and re-distributing the MAPP ES worker policy manual may also be an effective and cost-efficient strategy for improving workers' understanding of the program.

VIII. Appendix

Attachment A: Premium Schedule

PREMIUM SCHEDULE					
Sum of Adjusted Countable Unearned and Adjusted Earned Income		The Premium is:	Sum of Adjusted countable Unearned and Adjusted Earned Income		The Premium is:
From	**To**	**Premium**	**From**	**To**	**Premium**
$0	$10.00	$0.00	500.01	525.00	500.00
10.01	25.00	$0.00	525.01	550.00	525.00
25.01	50.00	25.00	550.01	575.01	550.00
50.01	75.00	50.00	575.01	600.00	575.00
75.01	100.00	75.00	600.01	625.00	600.00
100.01	125.00	100.00	625.01	650.00	625.00
125.01	150.00	125.00	650.01	675.00	650.00
150.01	175.00	150.00	675.01	700.00	675.00
175.01	200.00	175.00	700.01	725.00	700.00
200.01	225.00	200.00	725.01	750.00	725.00
225.01	250.00	225.00	750.01	775.00	750.00
250.01	275.00	250.00	775.01	800.00	775.00
275.01	300.00	275.00	800.01	825.00	800.00
300.01	325.00	300.00	825.01	850.00	825.00
325.01	350.00	325.00	850.01	875.00	850.00
350.01	375.00	350.00	875.01	900.00	875.00
375.01	400.00	375.00	900.01	925.00	900.00
400.01	425.00	400.00	925.01	950.00	925.00
450.01	475.00	450.00	9950.01	975.00	950.00
475.01	500.00	475.00	975.01	1,000.00	975.00

Note: If the sum of Adjusted Countable Unearned Income and Adjusted Earned Income is greater than $1,000.00 per month, the premium shall be equal to the exact dollar amount of this sum.

Attachment B: Eligibility Trends for MAPP Enrollees

ELIGIBILITY TRENDS FOR MAPP ENROLLEES Data as of August 15, 2002								
MONTH OF YEAR	NEW MAPP ENROLLEES [1]	# WITH ELIGIBILITY PRIOR MONTH [2]	% WITH ELIGIBILITY PRIOR MONTH [2]	# WITH ANY PRIOR ELIGIBILITY [3]	% WITH ANY PRIOR ELIGIBILITY	# WITH POST MAPP ELIGIBILITY [4]	MAPP DISENROLLMENTS [5]	MAPP NET NEW ENROLLEES [6]
January 2000	32	7	21.9%	24	75.0%	8	0	32
February 2000	14	5	35.7%	10	71.4%	7	1	13
March 2000	39	19	48.7%	33	84.6%	17	0	39
April 2000	40	17	42.5%	34	85.0%	19	0	40
May 2000	61	32	52.5%	52	85.2%	16	3	58
June 2000	113	67	59.3%	96	85.0%	37	3	110
July 2000	133	81	60.9%	117	88.0%	41	3	130
August 2000	107	59	55.1%	93	86.9%	40	6	101
September 2000	104	52	50.0%	91	87.5%	35	8	96
October 2000	124	71	57.3%	108	87.1%	36	9	115
November 2000	117	76	65.0%	97	82.9%	28	10	107
December 2000	132	106	80.3%	121	91.7%	40	20	112
January 2001	158	87	55.1%	134	84.8%	43	14	144
February 2001	95	58	61.1%	81	85.3%	23	10	85
March 2001	99	62	62.6%	86	86.9%	28	17	82
April 2001	76	47	61.8%	67	88.2%	21	19	57
May 2001	85	56	65.9%	78	91.8%	19	24	61
June 2001	78	49	62.8%	62	79.5%	16	29	49
July 2001	79	56	70.9%	70	88.6%	15	20	59
August 2001	76	44	57.9%	66	86.8%	15	19	57
September 2001	92	58	63.0%	80	87.0%	14	29	63
October 2001	80	43	53.8%	68	85.0%	12	36	44
November 2001	93	55	59.1%	81	87.1%	20	35	58
December 2001	73	45	61.6%	59	80.8%	11	42	31
January 2002	183	115	62.8%	157	85.8%	13	41	142
February 2002	281	220	78.3%	254	90.4%	23	38	243
March 2002	238	158	66.4%	212	89.1%	19	60	178
April 2002	214	145	67.8%	185	86.4%	6	47	167
May 2002	219	151	68.9%	187	85.4%	12	68	151
June 2002	199	135	67.8%	179	89.9%	4	72	127
Sums:	**3434**	**2176**	**63.4%**	**2982**	**86.8%**	**638***	**683**	**N/A**

[1] The minimum MAPP enrollment date for an individual

[2] Individuals having a non-MAPP eligibility segment with an end date between the minimum MAPP start date and 31 days prior to the minimum MAPP start date

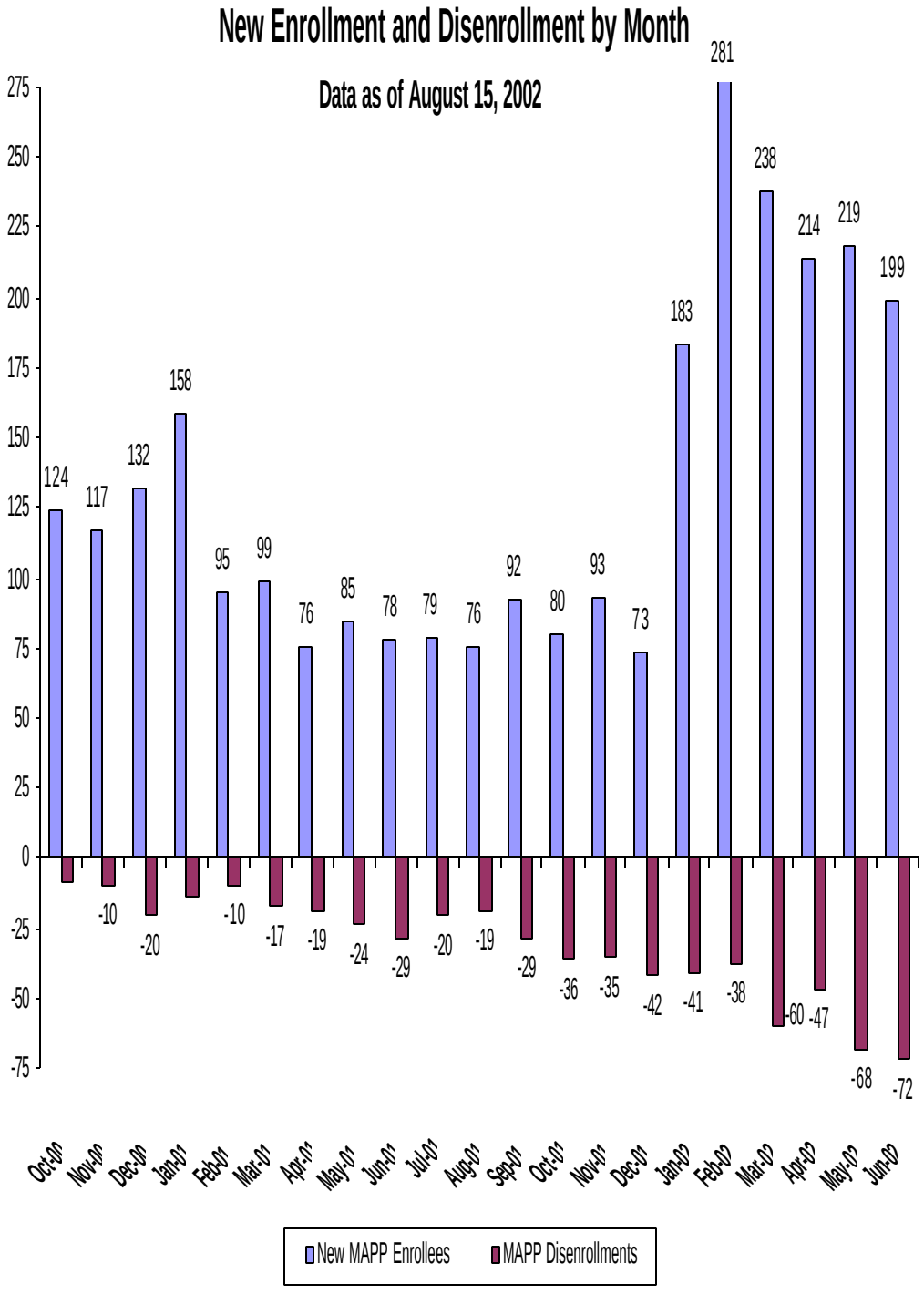
[3] Individuals having a non-MAPP eligibility segment with an end date before the minimum MAPP start date

[4] Individuals having a non-MAPP eligibility segment beginning after their minimum MAPP start date

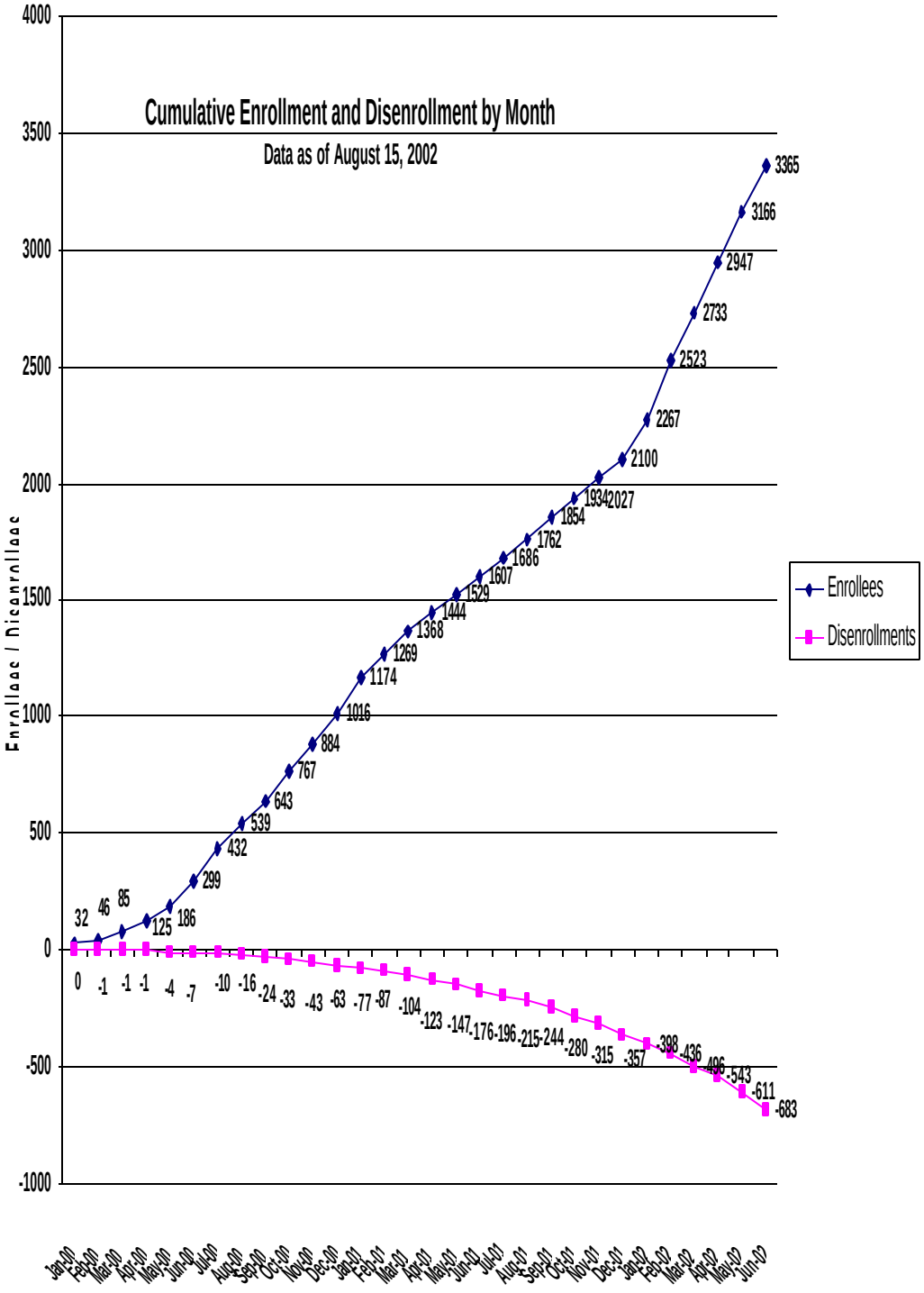
[5] The maximum MAPP end date for an individual (most recent disenrollment). Disenrollees include all MAPP enrollees that have not re-enrolled in MAPP as of the month of this report. Data is not provided for the most recent quarter because enrollees may have new eligibility segments that are not yet captured in the data. Those individuals will be included in the following quarter.

[6] New MAPP enrollees minus MAPP disenrollees for each month

Attachment C: New Enrollment and Disenrollment by Month



Attachment D: Cumulative Enrollment vs. Current enrollment by Month



Attachment E: County Breakdown of Disabled Medicaid Enrollees versus MAPP Enrollees

County Breakout of Disabled Medicaid Enrollees versus MAPP Enrollees (Enrollment data as of August 22, 2002)

Total Disabled Medicaid Enrollees (Including MAPP)		
County	Count	% of Total
Milwaukee	47,988	29.01%
Dane	9,492	5.74%
Racine	5,883	3.56%
Brown	5,306	3.21%
Rock	4,923	2.98%
Waukesha	4,556	2.75%
Marathon	4,264	2.58%
DHSS DCS Unit (Katie Beckett)	4,194	2.54%
Winnebago	3,763	2.27%
LaCrosse	3,539	2.14%
Outagamie	3,169	1.92%
Eau Claire	3,122	1.89%
Sheboygan	2,803	1.69%
Fond du Lac	2,657	1.61%
Wood	2,390	1.44%
Manitowoc	2,352	1.42%
Waupaca	2,203	1.33%
Barron	2,077	1.26%
Douglas	2,066	1.25%
Jefferson	1,896	1.15%
Walworth	1,862	1.13%
Chippewa	1,849	1.12%
Grant	1,809	1.09%
Portage	1,671	1.01%
Dodge	1,670	1.01%
Marinette	1,624	0.98%
Wasthington	1,578	0.95%
Sauk	1,456	0.88%
Oneida	1,296	0.78%
Columbia	1,293	0.78%
Monroe	1,266	0.77%
Shawano	1,245	0.75%
Clark	1,225	0.74%
Trempeleau	1,214	0.73%
Polk	1,135	0.69%
Dunn	1,123	0.68%
St. Croix	1,106	0.67%

MAPP Enrollment		
County	Count	% of Total
Dane	339	11.28%
Milwaukee	236	7.85%
Kenosha	148	4.92%
Waukesha	123	4.09%
Winnebago	101	3.36%
Marathon	98	3.26%
LaCrosse	96	3.19%
Brown	86	2.86%
Outagamie	83	2.76%
Washburn	70	2.33%
Sheboygan	68	2.26%
Racine	67	2.23%
Eau Claire	66	2.20%
Wood	65	2.16%
Douglas	63	2.10%
Fond du Lac	59	1.96%
Green	48	1.60%
Rock	44	1.46%
Washington	44	1.46%
Waushara	44	1.46%
Barron	43	1.43%
Grant	43	1.43%
Manitowoc	43	1.43%
Jefferson	42	1.40%
St. Croix	42	1.40%
Monroe	39	1.30%
Sauk	38	1.26%
Ashland	37	1.23%
Walworth	37	1.23%
Chippewa	33	1.10%
Trempealeau	32	1.06%
Portage	31	1.03%
Ozaukee	30	1.00%
Dunn	29	0.96%
Polk	29	0.96%
Lincoln	27	0.90%
Calumet	26	0.86%
Vernon	26	0.86%
Columbia	25	0.83%
Adams	23	0.77%
Clark	23	0.77%
Taylor	23	0.77%
Marinette	22	0.73%
Shawano	21	0.70%

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Total Disabled Medicaid Enrollees (Including MAPP)		
County	**Count**	**% of Total**
Green	856	0.52%
Rusk	809	0.49%
Washburn	793	0.48%
Sawyer	779	0.47%
Jackson	771	0.47%
Price	770	0.47%
Crawford	760	0.46%
Adams	735	0.44%
Waushara	727	0.44%
Richland	700	0.42%
Pierce	669	0.40%
Door	617	0.37%
Vilas	589	0.36%
Calumet	571	0.35%
Burnett	571	0.35%
Green Lake	557	0.34%
Bayfield	511	0.31%
Buffalo	510	0.31%
Iowa	497	0.30%
Forest	484	0.29%
Kewaunee	474	0.29%
Marquette	462	0.28%
Lafayete	372	0.22%
Iron	352	0.21%
Pepin	285	0.17%
Menominee	231	0.14%
Florence	199	0.12%
Other	4	0.00%
Total	**165,442**	**100.00%**

MAPP Enrollment		
County	**Count**	**% of Total**
Iowa	19	0.63%
Kewaunee	18	0.60%
Green Lake	17	0.57%
Iron	17	0.57%
Waupaca	17	0.57%
Price	16	0.53%
Rusk	16	0.53%
Richland	15	0.50%
Bayfield	14	0.47%
Oneida	14	0.47%
Marquette	13	0.43%
Sawyer	13	0.43%
Jackson	12	0.40%
Pierce	11	0.37%
Dodge	10	0.33%
Langlade	10	0.33%
Burnett	9	0.30%
Oconto	9	0.30%
Door	8	0.27%
Juneau	8	0.27%
Lafayette	7	0.23%
Pepin	6	0.20%
Buffalo	5	0.17%
Crawford	5	0.17%
Florence	4	0.13%
Forest	1	0.03%
Total	**3,006**	**100.00%**

Note: Disabled Medicaid enrollees includes individuals with the following med stat codes:

01,02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 21, 22, 23, 24, 25, 26, 28, 40, 41, 42, 43, 44, 45, 46, 47, 90, 91, 92, 93, A1, A2, AD, BD, 5C, 6C, 5D, 6D, DC, DD, DN, IC, IM, L1, L2, L3, L4, L5, L6, L7, L8, M3, M4, M5, M6, M7, M8, M9, MP, Q1, Q2, QN, QR, QW, RC, RN, SB W2, W3, W4, W5, W6, WA, WB, WC, WP, WR, WI, WW, ZN, ZZ

Attachment F: MAPP Enrollment by Premium Status

MAPP Enrollment by Premium Status
SFY 2001 (July 1, 2001 – June 30, 2002)

Benefit Month	Enrollees With Premium Med Stat Code	Enrollees Without Premium Med Stat Code	Total Enrollment	% of Total With Premium Med Stat Codes
July 2001	238	1,194	1,432	17%
August 2001	244	1,250	1,494	16%
September 2001	256	1,310	1,566	16%
October 2001	255	1,348	1,603	16%
November 2001	262	1,394	1,656	16%
December 2001	262	1,424	1,686	16%
January 2002	238	1,603	1,841	13%
February 2002	281	1,793	2,074	14%
March 2002	355	1,938	2,293	15%
April 2002	390	2,059	2,449	16%
May 2002	392	2,254	2,646	15%
June 2002	397	2,387	2,784	14%

Attachment G: MAPP Premium Payment History

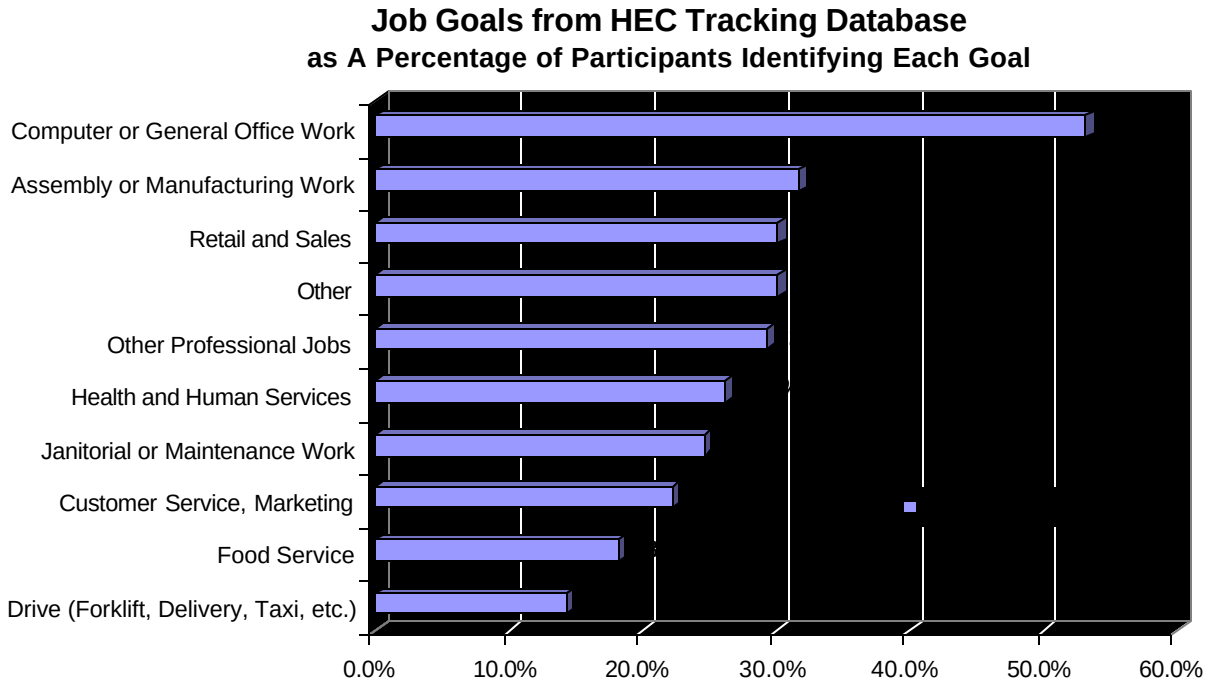
MAPP Premium Payment History

Total Premium Payments Received July 1, 2000 - June 30, 2001
State Fiscal Year 01: $207,800

Total Premium Payments Received July 1, 2001 - June 30, 2002
State Fiscal Year 02: $493,010

State Fiscal Years 01 and 02					
Benefit Month	**Payments Received**	**Average Payment**	**Maximum Payment**	**Total Paid Claims**	**Premiums as % of Claims**
July 2000	$6,785	$98.33	$475	$188,635	3.60%
August 2000	$7,975	$96.08	$625	$228,359	3.49%
September 2000	$8,345	$82.62	$625	$268,196	3.11%
October 2000	$11,385	$93.32	$675	$302,697	3.76%
November 2000	$13,600	$95.77	$675	$353,211	3.85%
December 2000	$15,655	$97.24	$675	$434,934	3.60%
January 2001	$20,085	$106.27	$675	$575,028	3.49%
February 2001	$21,900	$105.29	$675	$638,063	3.43%
March 2001	$23,640	$105.07	$750	$694,051	3.41%
April 2001	$25,000	$106.84	$750	$659,804	3.79%
May 2001	$26,605	$111.32	$750	$731,564	3.64%
June 2001	$26,825	$124.77	$750	$685,907	3.91%
July 2001	$29,635	$134.10	$750	$760,207	3.90%
August 2001	$31,760	$136.90	$750	$822,646	3.86%
September 2001	$34,425	$140.51	$875	$790,763	4.35%
October 2001	$34,465	$137.31	$875	$930,389	3.70%
November 2001	$35,465	$141.86	$875	$881,981	4.02%
December 2001	$34,340	$141.90	$875	$926,712	3.71%
January 2002	$34,870	$148.20	$750	$1,119,800	3.11%
February 2002	$38,200	$153.41	$875	$1,057,536	3.61%
March 2002	$47,875	$152.96	$875	$1,211,251	3.95%
April 2002	$56,325	$156.46	$875	$1,420,363	3.97%
May 2002	$56,675	$156.13	$875	$1,524,032	3.72%
June 2002	$58,975	$157.69	$875	$1,507,417	3.91%

Attachment H: Job Goals from HEC Employment Plans[36]



[36] One-hundred twenty-six HEC participants identified 353 job goals (262 unique goals). This graph represents the percentage of respondents who identified each job goal (N=126).

Attachment I: IRWE and MRE Examples

Examples of Impairment Related Work Expenses (IRWE):

- Attendant care services (at work, for transportation, other)
- Diagnostic procedures
- Durable medical equipment (plus installation, maintenance, and associated repair costs)
- Essential non-medical appliances and devices (electric air cleaner, etc.)
- Exterior home modifications that allow access to the street or to transportation (ramps, railings, pathways, etc.)
- Interior home modifications which create a work to accommodate impairment (enlargement of doorway, etc.)
- Interpreter (at workplace)
- Job Coach
- Medical devices
- Measuring instruments
- Mileage allowance (to and from work)
- Modified audio/visual equipment (enlarged monitor, speech activated computer, etc.)
- Pacemakers
- Physical therapy
- Prostheses
- Reading aids
- Regularly prescribed medical treatment or therapy and physician's fees associated with this treatment
- Respirators
- Routine prescription drugs
- Special work tools
- Traction equipment, braces
- Typing aids
- Vehicle modification (plus installation, maintenance, and associated repair costs)
- Wheelchairs
- Work animal and associated costs (plus food, maintenance, and veterinary services)
- Workspace modifications (adjustable desk, etc.)
- Work subsidy (increased supervision, etc.)

Examples of Medical Remedial Expenses

- Abdominal supports; Back supports
- Acupuncture
- Artificial teeth, eyes, limbs
- Attendant care (at workplace or other)
- Audio/visual equipment, such as screen magnifiers
- Automobile or van modification
- Automobile modified equipment; Autoette
- Bathtub/Shower accessibility modifications and
- related adaptive hardware
- Bed pads; Bed boards
- Chiropractor
- Computer/desk modifications
- Convalescent home
- Diapers
- Dietician/Nutritionist Services or Information
- Elevator
- Eyeglass prescriptions
- Excess energy costs related to a medical condition
- Handrails
- Healing services
- Health institute fees
- Health spa
- Hearing aids
- Home improvements made for medical reasons: air conditioning system, bathroom on the first floor, ramps, doorway modifications, etc.
- Hydrotherapy
- Inclinator or other device for managing stairs
- Invalid chair
- Job coach
- Life-care fee (medical portion only)
- Lodging on trips to obtain medical care
- Medicaid co-payments
- Medical supplies
- Modified clothing
- Modified eating utensils
- Outstanding medical bills
- Practical/other nonprofessional nurse for med services
- Prescription drugs
- Private health insurance premiums
- Reclining chairs
- Registered nurse
- Rental of medical equipment
- Repair of special medical equipment
- Respite care
- Special mattresses
- Special plumbing fixtures
- Special telephone equipment and associated repair costs
- Special technology needs
- Transportation costs for medical visits
- Vitamin Supplements
- Wheelchair; other equipment
- Wages of guide/assistant
- Whirlpool
- Work animals and associated maintenance costs (plus food, maintenance, and veterinary services)

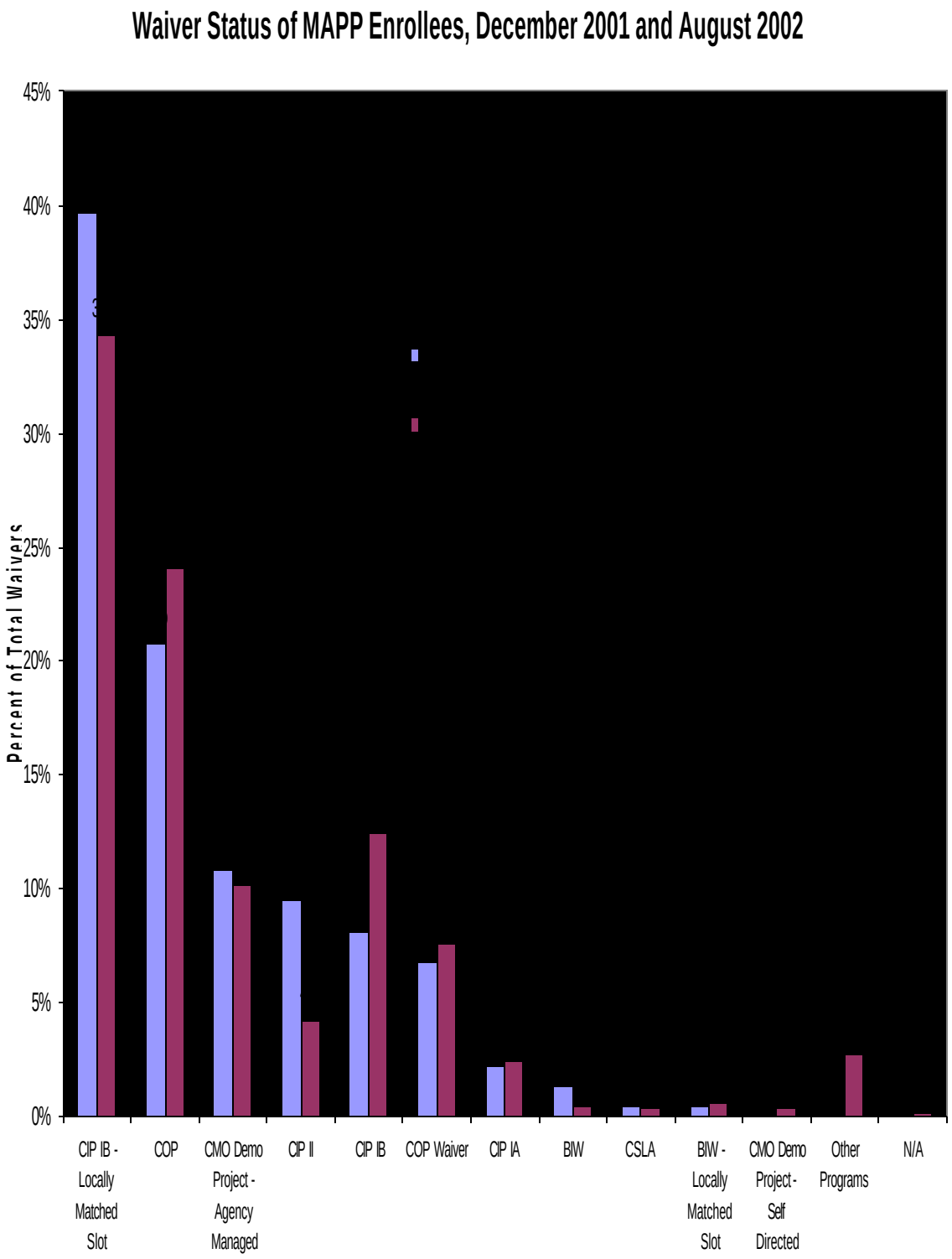
Attachment J: Total MAPP Health Care Expenditures By: Category of Service, Age, Income and Premium

MAPP Payments by Program Year and *Age Group*				
	Program Year One		**Program Year Two**	
Age Group	**Amount Paid**	**Percent**	**Amount Paid**	**Percent**
16-19	$4,465	0.1%	$1,708	0.0%
20-29	$248,802	6.5%	$730,345	6.9%
30-39	$882,499	22.9%	$2,639,077	24.9%
40-49	$1,164,200	30.3%	$3,175,084	30.0%
50-64	$1,376,051	35.8%	$3,641,143	34.4%
65-74	$163,596	4.3%	$328,415	3.1%
75+	$8,375	0.2%	$62,776	0.6%
	$ 3847,987	**100.0%**	**$10,578,548**	**100.0%**

MAPP Payments by Program Year and *Earned Income*				
	Program Year One		**Program Year Two**	
Income	**Amount Paid**	**Percent**	**Amount Paid**	**Percent**
$0	$512,474	13.3%	$1,205,986	11.4%
$ 1-$100	$805,053	20.9%	$2,595,762	24.5%
$ 101-$250	$692,244	18.0%	$1,939,254	18.3%
$ 251-$500	$853,613	22.2%	$2,282,641	21.6%
$ 501-$1000	$776,198	20.2%	$2,018,721	19.1%
$1001-$5000	$208,406	5.4%	$536,185	5.1%
	$ 3,847,987	**100.0%**	**$ 10,578,548**	**100.0%**

MAPP Payments by Program Year and *Premium*				
	Program Year One		**Program Year Two**	
Premium	**Amount Paid**	**Percent**	**Amount Paid**	**Percent**
$0	$3,063,781	79.6%	$8,636,528	81.6%
$25	$271,161	7.0%	$501,777	4.7%
$ 50-$75	$85,133	2.2%	$359,191	3.4%
$100-$175	$153,200	4.0%	$425,639	4.0%
$200-$575	$235,122	6.1%	$589,962	5.6%
$600+	$39,589	1.0%	$65,451	0.6%
	$ 3,847,987	**100.0%**	**$ 10,578,548**	**100.0%**

Attachment K: Waiver Status of MAPP Enrollees, December 2001 and April 2002



Attachment L: Waiver Status of MAPP Enrollees

Waiver Status of MAPP Enrollees

	December 2001	August 2002
Monthly MAPP enrollees	1714	3009
% of MAPP enrollees with waivers	12.5%	16.4%

LTS Code	LTS Name	December 2001 MAPP enrollees with December 2001 waivers[1]	% of Total December 2001 waivers	August 2002 MAPP enrollees with August 2002 waivers	% of Total August 2002 waivers
8	CIP IB - Locally Matched Slot	88	39.6%	212	34.3%
7	COP	46	20.7%	149	24.1%
C	CMO Demo Project -Agency Managed	24	10.8%	63	10.2%
2	CIP II	21	9.5%	26	4.2%
4	CIP IB	18	8.1%	77	12.5%
3	COP Waiver	15	6.8%	47	7.6%
1	CIP IA	5	2.3%	15	2.4%
6	BIW	3	1.4%	3	0.5%
5	CSLA	1	0.5%	2	0.3%
B	BIW - Locally Matched Slot	1	0.5%	4	0.6%
D	CMO Demo Project - Self Directed	-	-	2	0.3%
9	Other Programs	-	-	17	2.8%
-	N/A	-	-	1	0.2%
	Sum of all waivers	222		618	
	Unduplicated Enrollee Count[2]	214		493	

[1] MEDS eligibility data was queried to find December 2001 MAPP enrollees. HSRS LTS data was then queried to identify those MAPP enrollees who also had waiver eligibility in December 2001.

[2] A number of MAPP Enrollees were eligible for more than one waiver in a given month.